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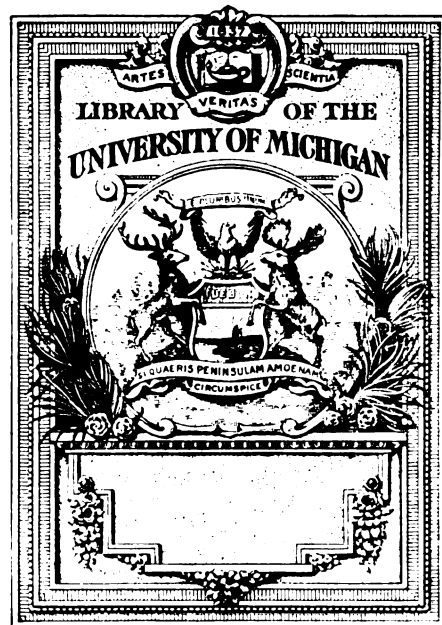
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*Cleveland Journal  
of Medicine*

Cleveland Medical Society









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# Cleveland Journal of Medicine

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# Cleveland Journal of Medicine

VOL. I

JANUARY, 1896

No. 1

## A Case Illustrating the Importance of Making a Careful Inquiry into the Cause of a Paralysis

BY CHAS. J. ALDRICH, M. D., CLEVELAND

*Neurologist to Cleveland General Hospital Dispensary*

ON the 19th of November, 1894, L. Q., an unmarried American laborer, twenty-one years of age, came into my office complaining of much headache. The headache would awaken him at about 3 or 4 o'clock in the morning and continue more or less constantly until near 4 in the afternoon when it would disappear, only to reappear the next morning. He was also aware of a sensible loss of vision.

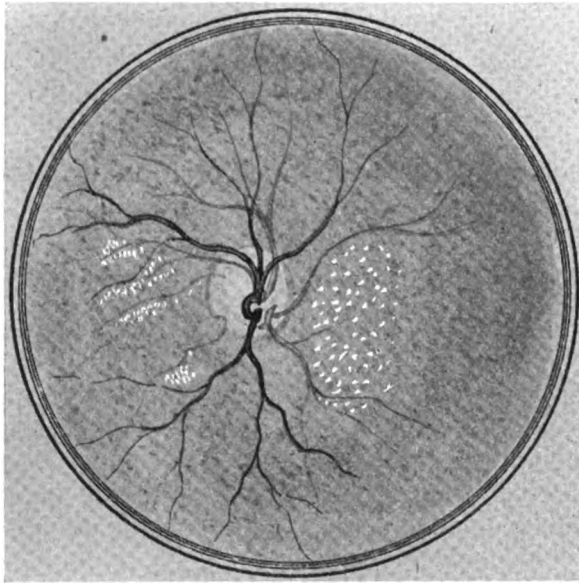
The headache has been very common during the last two months and the loss of eyesight remarked during the last two weeks. He has had no vertigo and has frequently vomited without nausea while suffering from the headaches, especially during the last two months. The patient is sallow with a peculiar greased-wax complexion. He is of medium height and fairly well nourished. The tongue is furred, appetite good, bowels regular, and amount of urine about normal. Although he has walked but a short distance, he seems to be breathless and exhausted. The pulse is small and quick. Temperature 100°F. Family history good. He had lung-fever when a child, also whooping-cough and measles, but neither diphtheria nor scarlatina. His boyhood was healthy.

About four years ago he began to experience vague rheumatoid pains in the limbs which have continued with more or less persistency. No his-

tory of swelling of the joints or limbs, venereal disease, intemperance, or exposure was obtained.

In September, 1893, without appreciable cause, the right side of his face was suddenly paralyzed. He is certain that he had considerable pain about his face at this time but whether it was before or after the paralysis he is not sure. Neither giddiness, temporary confusion, loss of consciousness, nor convulsions accompanied the advent of the paralysis. He thinks however, that he had suffered more from headache at about this time than formerly.

The paralysis disappeared in about ten days, but he declares that from that time he has not been up to his normal standard of health. He has a



No. 1.—RIGHT EYE

slight cough and embarrassed respiration, which probably depend more upon pulmonary edema than upon the heart-change; the latter consists of a slight left hypertrophy with a mitral insufficiency.

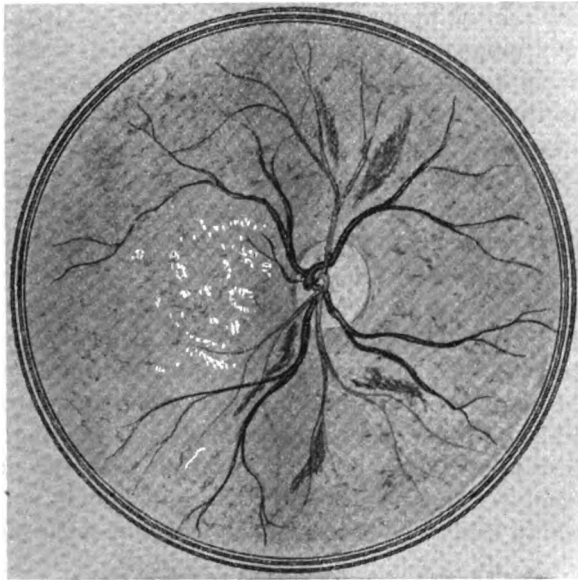
His pupils are equal but sluggish to light, affording an excellent ophthalmoscopic view of the fundi. The right fundus presented a beautiful picture of albuminuric retinitis; the left was affected but in less degree. Some days later Dr. Baker confirmed the ocular diagnosis and gave a bad prognosis.

It is to be noticed in the watercolor drawing of the fundus of the right eye that the white patches are seen in and about the forks of the arteries, and especially in the macular region. This is quite typical of this form of retin-



itis. The drawing was made at his first visit to my office and is marked No. 1.

In the watercolor No. 2 you will see a representation of the fundus of the left eye which shows small feathery hemorrhages which took place later. I kept him in the office long enough to secure a specimen of urine which was pale, of a specific gravity of 1 000, and contained about 25% bulk of albumin. On standing the urine deposited a floury sediment of epithelial cells and casts. The casts were of ordinary size, some granular and opaque, a less number hyaline. Withered, irregular-shaped epithelial cells studded some of the casts and lay free in the field. Some of the casts contained botryoidal fat-masses embedded in their substance. A few red blood-cells and



NO. 2—LEFT EYE, SHOWING HEMORRHAGES

casts were observed. This completed the chain of diagnostic symptoms of Bright's Disease, probably long latent, set into pernicious activity by some cause not discernible.

On going back carefully over the history of the facial paralysis I learned that when paralysis came on he was engaged in crating sewing-machines, and that after the attack he experienced difficulty in picking up nails without using his eyes to make up for loss of tactile sensibility. He was left-handed. He was also sure that during the first few days of his facial paralysis there was an appreciable loss of power in the left arm and hand, but thinks the leg and foot of the same side were unaffected. In the light of this history it became evident that his paralysis was not a

facial-nerve palsy but an incomplete hemiplegia probably due to an embolic plugging of one of the small arteries of the brain in the region of the face and arm centers.

He was admitted to the Cleveland General Hospital one week later, but nothing availed to check the rapid progress of the disease. His vision rapidly failed; cough with rusty sputum developed. A large wedge-shaped area of dullness developed over the posterior surface of the left lung, evidently an infarction. The expectoration became thin, sanious, foul-smelling and copious, evidently from the gangrenous disintegration of the infarct.

Drs. W. J. Scott and Dutton examined the case at this time at my instance. After his admission to the hospital, he sank rapidly and died in ten days, being completely blind before death. Unfortunately a postmortem was strenuously refused by his relatives.

This case is pregnant with practical suggestion. It will illustrate the necessity of some knowledge of the special departments of the healing art. It reminds us that all of the available means of diagnosis are never too many, and that none can be neglected with justice to our patients and to ourselves; that the ophthalmoscope as an aid to diagnosis should not be left to the specialist, but should be constituted one of the valued aids of the general practitioner of medicine; and that the eyes should be carefully investigated in all cases of persistent headache.

The importance of urinary examination in like cases is too apparent to need comment. But above all, when a patient comes with a paralysis of any part of the body, it is our duty to institute a thorough, careful, patient and exhaustive inquiry into its nature, distribution and extent, and to discover, if possible, its cause, pathologic, remote and exciting.

In the case related had the facial paralysis been recognized as a part only of an incomplete hemiplegia of central origin, I doubt not that the heart and kidneys would have been suspected, and mayhap a life saved, or at least prolonged.

*637 Central Avenue*

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## Observations on the Surgical Treatment of Peritonitis and Pelvic Suppurations

BY J. C. REEVE, JR., PH. C., M. D., DAYTON, O.

**A**BOUT two years ago, when abdominal section was first proposed for puerperal peritonitis, the writer was asked at a meeting of the local medical society if this measure was to be used for every case of the kind, or, if not, under what indications. Not being able to answer this question he at once undertook to look up the subject and was rewarded by

practically no information from the literature of that time. Since then professional experience in the matter has been gradually coming to light, so that at present we are quite certain of the very different pathologic processes that may mean puerperal fever, but are never certain of what to do or when to do it. Little on the subject in the current literature at hand or on the more general subject of operative treatment of peritonitis from other causes has been overlooked, and though in consequence this paper is largely a compilation, it has seemed that it might be of interest to some readers, especially as nearly every statement has fallen within the writer's personal experience.

First, in regard to the important subject of the diagnosis of peritonitis. It, as well as the treatment, has received some elucidation of late. Many years ago Dr. Reeve, Sr., insisted on the fact, then almost unknown, that peritonitis could do its worst with hardly a rise of temperature. The reaction against pulse-observation following the introduction of the thermometer threw undue dependence on the new instrument, and so firm was this trust that even today writers are warning against it. "For him who trusts the revelations of the thermometer in this affection it will prove an unreliable guide."<sup>1</sup> The obscurity of some forms of peritonitis makes the selection of serious operations for their treatment very trying; "it may run its fearful course with the greatest obscurity, so as to mislead the most careful diagnostician even up to its latest stages."<sup>2</sup> "In a few cases diagnosis is extremely difficult; instead of constipation generally present there may be diarrhea; instead of hard wiry pulse we may have a soft and dicrotic one; distension and tenderness may be absent. The most reliable signs in my experience are the steadily increasing frequency of the pulse, often with a *low or falling temperature*, and the facial appearance, this being either *pinched*, or *anxious or flushed*, and this latter is usually associated with delirium."<sup>3</sup> The length of time the trouble lasts may be misleading since it sometimes lies dormant for two or three weeks and then bursts out, or it is at its height and near its fatal end in one or two days. But with all these symptoms briefly mentioned of an inflammation of the peritoneum, the whole trouble after trauma of the genital tract may still be extraperitoneal, that is in the cellular tissue of the pelvis below the peritoneum, or encapsulated within the lower parts of the peritoneal cavity. To be sure these two last conditions usually may be told from general inflammation by bimanual examination, but one cannot always be told from the other. To add to the difficulty of diagnosis the real condition in child-bed fever is the retention of decomposing remains in the uterus. The systemic effects from the absorption may be so severe as to resemble closely general peritonitis and yet several cases where chills, high fever, rapid pulse, delirium and abdominal pain were present, have been seen by the writer to recover where the well-known treatment was adopted, of curetting and frequently irrigating the womb.



The selection then of operative treatment for puerperal inflammations of the last-named and other lesser forms, depends on whether there is a general peritonitis or whether the inflammation is limited to the pelvis, and in the last case, whether it is encapsulated from the peritoneal cavity, (extraperitoneal) whether it is tubal or ovarian, or whether it is extraperitoneal, within the broad ligament, cellular. Shall these latter (pelvic) conditions be attacked from above by abdominal section, or from below by vaginal incision? (Vaginal aspiration, single or repeated, will seldom be preferred to permanent drainage, though the writer has several times seen pelvic abscesses cured by a single aspiration.) A few years ago they were nearly all reached by abdominal section and now with the growing amount of work done through the vagina the tendency is to open all in that way. A better general rule would seem to be to approach them by the route which is shortest, above or below the pelvic brim.<sup>4</sup> Most extraperitoneal collections are nearest the vagina; but they may be nearest the groin and sometimes can be opened there entirely outside the peritoneum. Tubal and ovarian abscesses naturally fall to abdominal section with the hope of extirpation, but if their removal or drainage is impracticable they may still be drained from below with generally a cure as a result. If they already possess communications with the bladder or bowel they are better attacked from below to prevent general infection of the abdominal cavity.<sup>5</sup> To be sure these are distinct objections to vaginal incision or puncture. The mobility of the part effaces landmarks, and several cases have been reported of fatal hemorrhage from the puncture of large blood-vessels.<sup>6</sup> It has two distinct advantages of affording dependent drainage and of protecting the peritoneal cavity when pus is in the field. Finally, for peritonitis itself, incision and drainage are clearly indicated, but with these different results, that in localized collections cure may generally be expected, in general serous inflammation it sometimes may be, but in general suppurative peritonitis probably never. Barling<sup>7</sup> has reported six cases of the latter cured, but to judge from the histories given he has probably mistaken localized for general peritonitis. Grandin<sup>8</sup> reports six cases treated by drainage, all fatal, and such results are seconded by others.<sup>9</sup> Von Winckel<sup>10</sup> reports one unsuccessful attempt to cure a general suppurative peritonitis. Indeed, Frederick Treves, in his masterly chapters on peritonitis in the *British Medical Journal* (Feb. 3d, 1894) challenges the production of a cure of diffuse peritonitis by any means. Miles F. Porter has lately published what is certainly a case of suppurative peritonitis cured by abdominal incision, irrigation and drainage, and collects several other late cases. (*American Gynecologic and Obstetric Journal*, October, '95.) In the face of this discouraging experience Coe<sup>11</sup> wisely proposes that in every case of supposed suppurative peritonitis an abdominal incision be made with the hope that the trouble may prove localized, and so be drained or attacked later

from below. The following case elucidates so many of these newer points that it has seemed wise to report it. Though it is not a puerperal case the situation is the same and shows that the late statements<sup>1,2</sup>, that all cases of pelvic collections must be of puerperal origin are incorrect. Thomas (p. 485) properly includes in their causes operations on the pelvic organs.

One year ago the patient, a married woman of thirty, had for some time a continuous metrorrhagia. Three weeks before the operation she had a pelvic inflammation with profuse discharge, which was much benefited by glycerin tampons. Six days before, her attendant curetted the uterus with aseptic precautions. The temperature was then normal and remained so for three days, when fever began and a chill occurred. Three days after this, at night, I was asked to operate, and the hour made the patient's serious condition seem even hopeless. Her temperature was 100.8°, the pulse 140, respiration was rapid, she complained of want of breath, the abdomen was distended and extremely tender, and there were vomiting and anxious facies. Both lateral fornices of the vagina were filled, especially the one on the right. Her attendant agreed that general peritonitis was in all probability present, and that the abdomen should be opened for inspection, but as he much preferred the vaginal route as safer for the evacuation of abscesses, the operator assented to finishing the operation by that route in case it seemed better. Upon opening the abdomen in Trendelenberg's position the vessels of the intestines were found much injected, there was considerable reddish peritoneal fluid and a few flakes of lymph, but no pus; the uterus and adnexa were red and swollen. The tubes were empty, thus proving, if proof were necessary, the falsity of the claims made a few years ago on no foundation whatever, that all pelvic abscesses were intratubal. The incision was partly closed after distributing a large gauze drain in the pelvis. The patient was now changed to the lithotomy position, and by the aid of a drop-light and forehead mirror an aspirator needle was thrust into the right vault of the vagina and followed by a bistoury. The incision was enlarged by forceps and the multilocular abscess cavity was washed out. In spite of great care a deep vessel of considerable size was severed, and in attempting to check the flow by hot water and pressure a serious amount of time and blood was lost, considering the patient's condition. It was evident that continuous and fatal hemorrhage was before us unless pressure forceps could be placed. This was at last accomplished out of sight and by the merest chance and the instrument left in place. There was considerable discharge from both abdominal and vaginal incisions, and an improvement was at once apparent in every way. In forty hours the forceps were replaced by a drainage tube and the packing in the abdominal incision renewed. With some interruption the improvement continued for a week, when the patient steadily grew worse till on the tenth day she was in all ways as bad as before and with a temperature of 104°. It must not be for-

gotten by practitioners who undertake the after-care of operations that this part often taxes every faculty of the surgeon as much as, or even more than the operation itself. For example, was this relapse due to an infection of the open abdominal cavity from without, or to an extension to new parts of the abdomen of already existing peritonitis? Was it due to insufficient drainage from the abdominal incision or from the vagina, or both? Could it be that new centers of suppuration were forming within the cellular tissue of the pelvis undrained or at best partially drained by the tube? After much anxiety we decided that insufficient drainage below was at the bottom of the matter, and with some trouble this was corrected. The patient then made a slow but steady recovery, but it was over two weeks before the pulse fell below 100, being at one time during the relapse 150, and often 120, the respiration ranging from 20 to 34.

This case was certainly not one of fully developed peritonitis, but that it was the beginning of one, cannot be doubted. Whether the course of the abdominal inflammation was checked by the thorough drainage of the lower part of the cavity, or whether without the latter it would have gone to a general and suppurative peritonitis, are important questions which with much probability may be answered in the affirmative. This form of double operation, opening the abdomen first for inspection or drainage and then attacking the collection from below, the writer finds has been proposed and practiced by Noble<sup>18</sup> as a routine procedure, and defended by him because of the danger of vaginal incision without the real state of affairs within the pelvis being known. It is evident that a better plan for this particular case could not have been chosen.

The latest proposal is to cure general peritonitis by extirpation of the uterus and its appendages. Against it the protest of Von Winckel in the *Therapeutische Monatshefte* for April, '95, may be translated:

"I thoroughly agree with Boldt that such operations, also laparotomy, can be indicated only by the greatest danger to life; vaginal hysterectomy only in the most undoubted cases. For as a rule this subject deals with young individuals, whose unnecessary crippling in this manner certainly amounts to a crime. I cannot at all agree that if the uterus is the starting-point of puerperal sepsis, or because it is, it must be removed. If the peritonitis is diffuse, fibrous-suppurative with copious exudation, then the interference with the diaphragm and heart, the respiration and circulation, is the most pressing danger, and the uterus adds no further danger to the presence of infecting germs in the pelvis and abdomen. When we relieve the diaphragm, improve the respiration and circulation and provide a favorable and continuous drainage for the pus present and to be, then the peritoneum with all its streptococci and other microbes, recovers, as the diseased uterus in countless cases recovers. If this observation and experience are acknowl-

edged, then the indication for the exceptional cases according to my opinion should be precise, and is as follows: In a diffuse-suppurative puerperal peritonitis, where there is little or no bulging of the exudation in Douglass culdesac to be felt below and where the possibility of favorably entering such by this route is slight, lies the only ground for a laparotomy. On the contrary, the same disease with a bulging downward of the culdesac, and a channel from above to the latter, requires only the free opening of the culdesac into the vagina, with drainage of the peritoneal cavity. In both cases, of course, the adnexa when incurably diseased, (pyosalpinx, ovarian tumors) will be removed from one or both sides, but the uterus left untouched. Should the patient improve after these procedures, the suppuration lessens through the regular overflow, and further operating is not needed. But should the trouble, in spite of a lessening of the peritonitis, go on to a bilateral suppurative parametritis, then alone is a total extirpation of the uterus and appendages indicated. At once to extirpate the uterus merely because it was the starting-point of the disease, and even before we have waited to see whether the evacuation of copious exudate alone betters the patient, I hold to be over-hasty and motiveless, since we remove with the uterus by no means all the noxious products, but on the contrary, leave behind a large quantity in the abdominal cavity." Price<sup>14</sup> urges similar objections. Of course hysterectomy for peritonitis may be advisable in particular cases where there is extensive pelvic suppuration on both sides of the uterus, exceptional drainage being secured by this means.

A few points may be added on the technic of the measures already mentioned. It will be noticed that in the above operation the abdominal cavity was not washed. Washing in suppurative conditions has seemed to the writer irrational on several grounds. In the first place, the use of chemical solutions of sufficient strength to be germicidal, is not to be thought of. If, then, the irrigation is for the mechanical flushing out, this is impossible because of the numerous separate pockets shown by Hadra<sup>15</sup> to exist in the abdominal cavity, formed by the various mesenteries, etc. Only by complete evisceration he shows, could all of these be reached by the irrigating nozzle or fluid. Attempted irrigation only serves to spread the existing infection farther; and since Ziegler has shown that the resistance of the peritoneal surface to bacterial invasion depends directly on its dryness, (as indeed, do most tissues of the body) had not irrigation better be discarded altogether? Further, its refreshing effect to the depressed patient has always seemed doubtful. Baring and Hunter Robb are similarly opposed to this measure. Instead, the writer has satisfied himself with careful sponging of the viscera by soft gauze, sometimes carried deeply on and over the point of the forceps. The breaking of adhesions is carefully avoided, even if the offending organ is not reached; breaking them allows the infection to spread and cause a

general peritonitis<sup>16</sup>. Drainage is accomplished by widespread gauze strips between the viscera, seconded, perhaps, by a large tube, the incision being partly or not at all closed (Bernays). Another measure is of value where complete obstipation exists from paralysis of the intestine due to septic absorption. This is relief of the distended bowel from gas or pus by aspiration or incision, thus allowing it to resume its peristaltic contraction. The writer has practiced this with much apparent benefit for over a year, in cases other than puerperal, and has lately seen it advocated by Miles F. Porter<sup>17</sup> and by Henrotin<sup>18</sup>, who go a step farther and wash out the intestines and sometimes make an artificial anus. It is the only thing to be tried in the presence of palsy, for purgatives in any quantity are absolutely without effect, and the puncture and incision can be closed, if desired, by a few stitches. In regard to attacking abscesses from the vagina, Henrotin<sup>19</sup> has furnished lately the first and only rational technic. In brief, it is this: an incision is made through the mucous membrane only, just behind or before the cervix; when the cellular tissue is reached, a blunt instrument or the finger is used to explore in one direction or another for the collection. This method must amplify very much the scope of this route and add to its safety and certainty.

<sup>1</sup>—H. C. Coe, *Am. Gyn. and Obstetric Journal*, page 515, '95.

<sup>2</sup>—T. Gaillard Thomas, *Diseases of Women*, October 2d, page 483.

<sup>3</sup>—Gilbert Barling, *British Medical Journal*, page 122, '94, I.

<sup>4</sup>—Henrotin, *American Journal of Medical Science*, October, '85.

<sup>5</sup>—Henrotin, *American Journal of Medical Science*, October, '95.

<sup>6</sup>—*American Journal of Obstetrics*, August, '95, page 214, *et seq.*

<sup>7</sup>—G. Barling, *op. cit.*

<sup>8</sup>—Grandin, *American Journal of Obstetrics*, August, '95.

<sup>9</sup>—Louis Frank, *American Journal of Obstetrics*, Sept. '95.

<sup>10</sup>—Von Winckel, *Therapeutische Monatshefte*, April, '95.

<sup>11</sup>—H. C. Coe, *American Gynecologic and Obstetric Journal*, May, '95.

<sup>12</sup>—Noble, *American Obstetric Journal*, April, '94, page 447, and *American Journal of Obstetrics*, August '95, page 288.

<sup>13</sup>—Noble, *New York Gynecologic and Obstetric Journal*, June, '95, page 652.

<sup>14</sup>—M. Price, *American Gynecologic and Obstetric Journal*, October, '95.

<sup>15</sup>—Hadra, *New York Medical Journal*, June 2d, '95.

<sup>16</sup>—McBurney, *Medical Record*, No. 13, vol. XLVII, '95.

<sup>17</sup>—M. F. Porter, *American Gynecologic and Obstetric Journal*, October, '95.

<sup>18</sup>—Henrotin, *American Journal of Obstetrics*, August, '95.

<sup>19</sup>—Henrotin, *American Gynecologic Journal*, June, '95.

## Ruptured Tubal Pregnancy

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IN appearing before your society it is not my intention to spend any of the short time allotted me in theorizing, but I hope to make a few practical points sufficiently prominent to be of value to the majority. I shall confine my remarks to the symptoms, diagnosis and treatment of tubal pregnancy, closing with a report of two cases.

The symptoms are: (a) Usually a history of chronic uterine trouble. (b) A missed period of menstruation with the usual *objective* symptoms of normal pregnancy. (c) A sudden illness manifested by an attack of cutting pains in the lower abdomen and pelvis. (d) A sense of fullness in or about the rectum. (e) Bloody, shreddy discharge from the uterus. (f) Faintness, nausea and collapse. The degree which these symptoms attain is dependent upon the extent of the rupture and hemorrhage.

Diagnosis *after* rupture.—It is rare, indeed, that we have an opportunity of testing our diagnostic skill before rupture has occurred, because the consultant is not usually sought until alarming symptoms have arisen. The diagnosis is not difficult when a full history is obtained and carefully considered with the symptoms. Colicky pains in the lower part of the abdomen, together with *any* degree of collapse, nausea, or weak heart-action, should be an indication for an immediate examination by the vagina. The uterus will be softened and enlarged and its *mobility impaired*. If the blood has escaped into the peritoneal cavity the uterus may be crowded downward and forward toward the pubes. The pouch of Douglas and the vaginal vaults will be filled with an ill-defined doughy mass. If the rupture occurs within the folds of the broad ligament, and the blood be therein confined, the uterus is crowded to the side opposite the rupture and the mass is limited, well-defined and somewhat resistant.

TREATMENT.—If you are fortunate enough to have a case come to you before rupture has occurred, insist upon an immediate operation, as under the present method of operating the dangers are slight. When rupture has occurred, with symptoms of serious hemorrhage into the abdominal cavity, place your patient in a favorable position, apply an ice-bag and operate as soon as preparations can be made. Hemorrhage produces shock, and the shock will continue until the bleeding is arrested. Life is fast ebbing while

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you are waiting for the reaction which will never come. Be awake to the importance and the cause of this extreme condition. On the other hand, if the rupture occurs into the broad ligament, the hemorrhage will be limited, and consequently the shock less severe. It is in this class of cases that conservative measures can be practiced, such as applications of cold to the abdomen for two or three days, absolute immobility of the patient, and so forth. The patient should be confined to bed for three or four weeks until absorption takes place. Occasionally, however, in this form a septic condition arises later. When such a condition exists do not delay operation. I have given two forms—one urgently demands immediate operative interference, the other conservatism.

Within the past year a case of ruptured tubal pregnancy occurred in Cleveland, in which the diagnosis was made at 9 o'clock P. M. Hemorrhage was free into the peritoneal cavity and shock was prominent. It was decided to wait for reaction before operating, and measures were actively employed to obtain this. After seventeen hours' delay, in which the patient's condition did not improve, a resort was had to intravenous transfusion, and a celiotomy was performed. The peritoneal cavity was found filled with blood. The operation was completed, but the patient never rallied. Death followed within an hour. Would this result have occurred had operative measures been instituted sixteen hours earlier?

The first case which I desire to report has some unusually interesting symptoms, which, coupled with the extreme loss of blood, the hurried operation in most unfavorable surroundings and under adverse conditions, and the lack of a sufficient number of assistants, form an instructive clinical report.

On April 11, '94, I was called by my friend, Dr. George B. Farnsworth, of Brooklyn, to see a patient who was critically ill—Mrs. E——, aged 21, American. Menstruation began at 14 years; regular, without pain, of normal quantity, and lasting four days. She was married at the age of eighteen years, and has one child fifteen months old, healthy and nursing at the breast. Her personal history is negative.

*Present illness.*—In December, 1893, when her baby was 11 months old, the patient's menstrual periods returned and were normal in all respects, recurring regularly in January, February and March. On March 18th, when menstruation should occur, the flow appeared with no unusual symptoms; but instead of ceasing on the fourth day, as usual, a fair amount of bleeding continued daily, without pain or noticeable change in character until she arose early on the morning of the 26th. While dressing she felt a sudden cutting pain in the right iliac region, attended with nausea and faintness. The pain increased steadily until noon, when Dr. Farnsworth was summoned. The flow was more profuse and clotted after the onset of pain. The patient was kept absolutely quiet in bed, and in a few days felt

better; the bleeding, however, continued in spite of the usual remedies. She remained in bed until April 10, when she attempted to sit up while the bed-clothing was being changed. She became faint and extremely weak, and there was a return of the sickening pain, with feeling of distension of the abdomen and free bleeding from the uterus.

The doctor was again called and resorted to stimulation and ordered the foot of the bed raised to control bleeding and overcome the tendency to faintness. On examination Dr. Farnsworth found the vagina filled with clotted blood, and the uterus very tender and not freely movable. He at once suspected a possible tubal pregnancy, although the menstrual history was not in accord with such a conclusion. In a few hours the patient was made more comfortable but before leaving the doctor asked for counsel.

On the following morning, (April 11), I was called. I found her in bed with the head lowered and the extremities elevated; the face was blanched, all of the mucous membranes pale, shallow respiration, rapid and feeble pulse, a temperature of  $101^{\circ}$ , the abdomen distended and very sensitive to slight pressure. The vagina was filled with blood, the cervix softened and to the left side, the uterus partially fixed and a large boggy mass in the right vaginal vault and culdesac. Bimanual palpation elicited so much pain that it was not attempted. It was unmistakably a case of ruptured ectopic pregnancy. The primary rupture occurred March 26th, and the secondary one on the evening of the 10th of April, with unchecked hemorrhage. It was self-evident that prompt and active measures must at once be instituted, as our patient was sinking rapidly and in shock from the continuous hemorrhage. Removal to more favorable surroundings was precluded by her extreme condition, and preparations were immediately begun for operation.

Water was being heated in a wash-boiler while I was securing my instruments and assistants. Dr. P. Max Foshay administered the chloroform, Dr. Farnsworth stood opposite me and Miss Ritchie (my nurse) looked after the instruments and sponges. I hurriedly cut through the abdominal walls, and as the peritoneal cavity was opened, the intraabdominal pressure being so great, the blood was forced out to a height of eighteen or more inches, as though a large vessel had been cut. Within the cavity very firm blood-clots were found which were broken up before I came upon the uterus. With large pressure-forceps I secured the broad ligament on the right side between the uterus and the mass, keeping close to the former. This procedure checked for the most part any further bleeding and by so much increased the chance of a favorable result. Clearing away the clots, transferring the right broad ligament and removing the tube and its contents together with the ovary occupied but a short time. A half-hour was spent, however, in washing out the peritoneal cavity and freeing it of all blood, and sixteen gallons of boiled water were used at a high temperature.

Before this was finished, the patient ceased to breathe, the radial arteries were pulseless and it seemed that life was extinct. I requested Dr. Farnsworth to assist Dr. Foshay in keeping up artificial respiration while I hurriedly completed the toilet of the peritoneum and closed the incision, tamponading and draining after the method of Mikulicz.

After perhaps ten minutes of artificial respiration and the administration of several doses of strychnin hypodermically, the patient breathed. She was placed in bed on an incline with the head a foot lower than the pelvis and surrounded with artificial heat. This inclination of the body was maintained for one week (a horizontal position being afterward gradually assumed) in order to keep sufficient blood in the brain to avoid syncope. The outlook was most unpromising, and an unfavorable prognosis was given to the family. After an hour reaction came on and her strength slowly improved.

The fetus was not found as it was probably surrounded with clotted blood and was washed away unnoticed. The duration of gestation was probably eight weeks. Convalescence was slow but complete. In Oct. 1895, eighteen months after the operation this woman gave birth to a healthy child at full term.

CASE II.—During the evening of September 23, 1895, I was called in consultation by Dr. W. H. Capener.

Mrs. D—had been confined to her bed most of the time since September 16th. She was 35 years old, had been married 18 years, has 5 children and has had 2 miscarriages. The oldest child is 17 years old, the youngest is 10 years. The last miscarriage occurred 9 years ago.

The early menstrual history is as follows: Her menses began at the age of 10 years, were regular, normal in quantity and duration, but always accompanied by sick headaches. There was no dysmenorrhea.

Since the last miscarriage, 9 years ago, the patient has not been in good health. She was curretted at Charity Hospital several years ago, and was recently told by a Chicago physician that there was a growth in the pelvis. An operation was advised but declined.

History of present illness.—The patient menstruated at the proper time on July 25, 1895. On the morning of September 6th, while at the breakfast-table, she experienced a sudden cutting pain in the right iliac region, attended with faintness and slight nausea. She was compelled to seek her bed, and remained quiet all day. On getting up towards evening she experienced a sense of weight in the lower abdomen and observed that it was swollen and sensitive to pressure.

She did not feel well but kept about doing her household duties for several days, when suddenly there was a recurrence of the lancinating pain, faintness and nausea. She noticed now that there was bloating more generally throughout the belly and increasing soreness. She steadily be-

came worse until September 12th, when she had a chill, followed by fever. Dr. Capener was sent for and found her suffering intensely, and the abdomen tympanitic and painful to slight pressure. Hot applications to the abdomen and long hot douches were ordered and opiates were given for the relief of the pain. Soon after these measures had been instituted a bloody discharge appeared at the vulva, clotted and shreddy in character. Temporary relief followed. The flow, slightly varying in character day by day, persisted up to the time I was called, eleven days later.

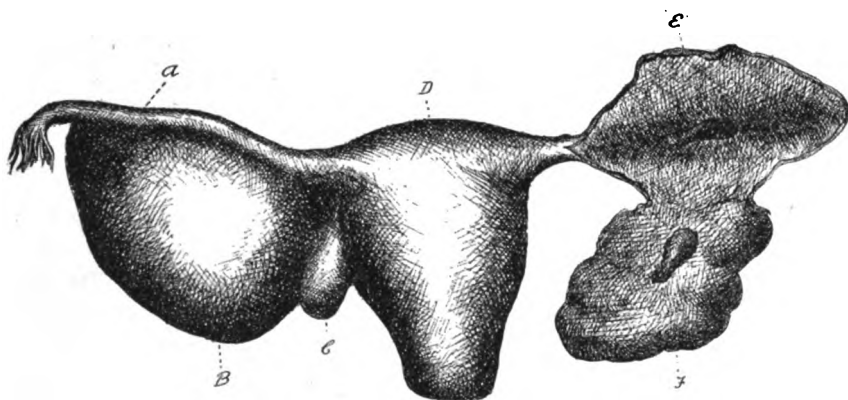
I found this patient in bed, with knees drawn up, an anxious expression of face, sallow skin, pupils contracted from the effect of the opiates, pulse 132 and very weak, and temperature  $103\frac{1}{2}^{\circ}$ . The abdomen was greatly distended. She had a chill during the day and had been vomiting more or less frequently for three days. The bowels were constipated. There was rectal and vesical tenesmus. The patient remarked that she had not been able to pass any urine since before daylight, and that the desire to micturate was intense. I passed a catheter supposing there was retention but to my surprise not a drop was to be obtained—there had been complete suppression since early morning.

On examination the vagina was found to be greatly encroached upon from above, the cervix crowded forward to the symphysis and immovable. A large boggy mass could be felt to the right and posterior to the cervix, and to the left an ovoid elastic mass the size of an orange. Bimanual examination could not be tolerated. I had no hesitancy in diagnosing a ruptured ectopic pregnancy and hemorrhage complicated with general septic peritonitis and acute suppression of urine. An unfavorable prognosis was given. Operative measures offered the only hope of saving her life, and after stating the case fully to the family their consent was obtained. The patient was carefully transported by ambulance to my hospital. The opiates were discontinued and strychnin and digitalis given hypodermically. Ten grains of calomel were administered and the night spent in preparing the patient by sponging the body and unloading the lower bowel by the use of large turpentine enemas.

Between midnight and morning six ounces of highly colored urine were passed, of a specific gravity of 1.036, and one-half albumin by bulk, after coagulation by heat. Microscopic examination revealed compound granular casts and degenerated epithelial cells from the kidney.

With Dr. Capener present and Dr. Lee administering chloroform, and assisted by Drs. Thomas and Clapp, I opened the abdomen at 9 o'clock A. M. on September 24th. The abdominal wall was fairly thick and there was free bleeding upon section. The parietal peritoneum was much thickened and the intestines were of a very dark reddish-brown color, deeply congested. There were both omental and intestinal adhesions to the abdominal walls. There was a pint or more of bloody serum in the peritoneal cavity.

Both old and recent adhesions were encountered in the pelvis, making it extremely difficult to remove the mass on the right side; the latter consisted of an enlarged tube and the broad ligament greatly distended with clotted blood. The tube was filled with a large clot in whose center was a well-defined cavity, probably the gestation-sac, although no fetus was found. The tube had been ruptured and the large clot was shelled out. The ovary of this side was intimately associated with the inflammatory mass about the broad ligament and was thoroughly disintegrated. The tube and broad ligament were ligated and removed, after handfuls of clotted blood had been scooped from the cavity of the distended broad ligament. The raw surfaces were tightly packed with iodoform-gauze while our attention was directed to the left side.



POSTERIOR VIEW—SPECIMEN FROM CASE II

*A*—Fallopian tube. *B*—large parovarian cyst, *C*—ovary. *D*—uterus, *E*—Right Fallopian tube containing large clot whose central cavity was gestation-sac. *F*—Clot within the broad ligament exposed.

Here was found a large, rounded, fluctuating mass, but owing to the congested and inflamed condition of all the structures, it was deemed wise to puncture it with a fine hypodermic needle to learn the nature of its contents. A pale, straw-colored fluid was withdrawn, and a cyst of the broad ligament was diagnosed. The broad ligament was split open and the greater portion of the cyst-wall separated from it. After the withdrawal of the fluid the freed portion of the cyst-wall was excised and the edges drawn into the lower angle of the wound and stitched to the abdominal wall. The cavity was carefully packed with iodoform-gauze.

At this time I was warned by Dr. Lee that the condition of the patient was grave. Hypodermics of strychnin, nitroglycerin and digitalis had been given at intervals during the operation. The gauze was hurriedly removed from the pelvis and the abdominal cavity thoroughly washed out with plain sterilized water at a temperature of 112°. A glass tube was used for drainage, and iodoform-gauze filled the pelvic cavity together with the intralig-

amentary cyst of the left side. While the patient was still in the Trendelenburg position two quarts of normal salt-solution were injected into the bowels. During the operation the pulse had been growing steadily weaker and continued at a minimum rate of 160 beats per minute. No hope of recovery could be entertained. The patient was surrounded with hot blankets and water-bottles; nitroglycerin, strychnin and digitalis were continued.

During the next 48 hours the pulse varied from 120 to 160. There was vomiting at frequent intervals during this time. Now the heart seemed steadily to fail and the vomiting became more frequent. I decided to push the digitalis, and from 9 o'clock A. M. to 5 P. M. of the same day 70 minims of the tincture were given in doses of 10 minims.

Several attempts to secure a movement of the bowels during this morning by enema were fruitless. However, shortly after the noon hour a large enema (2 quarts) of soapy water containing an ounce of glycerin and a tablespoonful of turpentine was injected high up into the bowels under considerable pressure. A large quantity of feces and gas was afterward passed and the belly was much less tense and tympanitic. At 5 P. M. the pulse showed the effect of the digitalis and the patient's condition was very much improved. Strychnin was now substituted for the digitalis.

On the fourth day the patient was given a small amount of nourishment by the mouth. A daily gain in her general condition was noticed and within ten days she was fully convalescing, with a normal temperature and pulse. Digestion was unimpaired, the bowels moved regularly and the kidneys gradually regained their normal condition so that before she left 'The Home' the microscope failed to show any structural change in these organs.

During the first three days succeeding the operation the patient was in such a low condition that, without opiates or any drugs other than the stimulants named, she has no recollection whatever of anything that transpired in that time; she could not even recall the visit of a priest on the third day. The nurse also, who was her constant attendant during the first two days after the operation, was unknown and unrecognized by the patient.

We may profitably study several points in this case and the first one is the importance of a full history and a knowledge of the symptoms that the patient has shown for a time prior to the first visit of the physician. I say *physician*, for it is he who is first called and not the surgeon, and upon the former must rest a great responsibility. A careful inquiry into the history and a close study of the symptoms of the patient will in most cases direct your attention to the possibility of an ectopic gestation with rupture, as it is unusual to be called before a rupture or bleeding from the uterus has occurred.

Given a case in which there has been chronic uterine trouble for months; a missed period of menstruation; a sudden cutting pain in the



lower abdomen more definite in either iliac region ; a faintness with nausea or collapse ; a sense of fullness or pressure in or about the rectum, and you have the symptoms of a typical case of ectopic pregnancy with rupture. If the cases were all typical, few errors would be made in diagnosis; but where only one or more of the above symptoms are encountered an examination of the uterus and appendages is necessary. The uterus is found to be softened and somewhat enlarged ; its mobility impaired ; and, if rupture has occurred with any considerable hemorrhage, a doughy mass is found in the culdesac and the cervix is crowded forward toward the pubic symphysis.

If rupture has occurred into the broad ligament, the vaginal vault on the side in which gestation has taken place will be encroached upon, and the mass will feel firmer and more resistant than when the blood is free in the abdominal cavity. The amount of blood poured out is much greater and the shock is more pronounced in the latter. In this variety operative measures are imperative, and no time should be lost in waiting for reaction, for the shock and collapse will be continuous, as is the bleeding.

Fortunately, at times the first rupture is of such limited extent that little blood is lost, but in a short time a secondary rupture more extensive than the first takes place, and the case is very critical. The hemorrhage may fill the abdominal cavity to a level with the umbilicus or higher. Death is liable to occur from shock, and if not, a septic peritonitis may arise to destroy all hope of a recovery from operative interference.

If the hemorrhage is slight and the embryo dies the symptoms may gradually subside and the patient regain a good degree of health. I believe numerous cases of this nature occur and are unrecognized.

But to again impress you with the symptoms of the more serious cases that are so liable to occur in your practice, I repeat that where rupture has occurred and there is internal hemorrhage, there will be sudden cutting pains, acute anemia, fainting, vomiting, yawning, cold perspiration, feeble rapid pulse, and collapse.

An hour previous to your visit the patient may have been enjoying the most perfect health, and this should not blind you to the serious nature of the symptoms which she presents.

*122 Euclid Avenue*

# Cleveland Journal of Medicine

THE OFFICIAL JOURNAL OF THE  
Cleveland Medical Society

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## EDITORIAL

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### Cleveland Journal of Medicine

THE opening of the year of our Lord, 1896, finds Cleveland at the brink of a long era of unexampled prosperity. This year's celebration of the centennial of the founding of Cleveland brings prominently to notice the fact that the first 100 years of the city's existence have not been marked by any superfluity of commercial enterprise. Cleveland has in truth been all these years rightfully reckoned a "slow" town. Hardly any line of municipal progress can be mentioned in which the city has not been painfully backward when compared to other, especially western, cities of its size. The one redeeming feature of the century is to be found in the solidity of

her slow growth which thus furnishes a most excellent foundation for future developments in wider fields. What other city in the union can boast that it has never known within its limits the failure of a chartered bank?

In the last three years a most remarkable change has been quietly going on in the spirit of the city. A younger generation of men, imbued with the fire of the example of Chicago, St. Louis and other western cities, has now the reins of the city's commerce well in hand. They do not propose to rest content with past achievements. They see a great future for Cleveland, and they intend, by devoting time, energy, and money to the work, to see that some of this great future is realized before they leave the scene of action. In no other city has a Chamber of Commerce grown so quickly or accomplished so much of good for the general welfare in so short a time. A prodigious amount of work has been done and more is doing. A true business revival of tremendous proportion is at hand. Since 1890 Cleveland's population has increased at a phenomenal rate. A new life marks almost every industry of the city. Cleveland is the center of the vessel industry of the Great Lakes, and the season just closed has been an unusually profitable one. The ship-building plants will be crowded to their utmost capacity in 1896. For some years Cleveland has been the undisputed center of the iron-ore market, and now is the dawn of the period in which it will be also the center of the steel-manufacturing industry. Even Andrew Carnegie admits that the south shore of Lake Erie is bound to become the center of steel-making, and Cleveland will fall heir to most of it. The location of the great Johnson plant at Lorain, a Cleveland suburb, is but the first step in the process. In the matter of surface railroads and business blocks, Cleveland is experiencing a remarkable growth. In fact, it would be difficult to name a line of progress in which this city is not now stepping to the fore. The Centennial Exposition of this autumn will be a fitting baptism for the new era of prosperity rather than a period to the century just closed.

In educational matters Cleveland is taking a high rank by reason of its excellent public school system, of its rapidly developing Western Reserve University, and, of particular interest to the medical profession, of its two thriving medical colleges and its two homeopathic schools, which rank high. The medical departments of Ohio Wesleyan University (formerly of Wooster University) and Western Reserve University are doing a work in medical education second to none in the west in quality. Favored

by endowments and otherwise they are bound to be heard from more effectually in the future.

Unquestionably in the last year or two Cleveland has made rapid strides towards becoming the medical center of Ohio. Never did a city see such a change for the better in professional spirit as this city has been witnessing for three years. The chief phenomenon of this improved professional feeling is the CLEVELAND MEDICAL SOCIETY. Founded in the early part of 1893 by a small group of young men who keenly felt the need of an organization which should secure freedom of speech and the abolition of clique and quelling of factional fights, at a time when the medical societies of the city were, and had long been, at a standstill, its success from the very start has been of a character so phenomenal as to have been practically unheard of in medical annals. It jumped into the arena full-armed with an original membership of about 100 physicians. From the very start its meetings were attended by five times as many physicians as it had ever before been customary to see at medical meetings in Cleveland. To such an extent has this been true that in the year 1894 the average attendance at the meetings of the Society was 135. It is of interest to quote similar figures from the other large societies of the country for 1894, as they were collated by Dr. W. H. Humiston in his address as retiring president in January, 1895. In a number of the leading local medical societies of the country he found that the average attendance varied from 40 to 133 for the year 1894. The total membership of the Society is at present 300, divided into 220 active or resident members, and 80 non-resident members. In proportion to the number of the regular profession in Cleveland it is believed that no other city has anywhere near so large a proportion of its physicians gathered into one society.

The life-history of the Society has been characterized by a vigor and activity unexampled in the annals of medical societies—certainly the CLEVELAND MEDICAL SOCIETY is admittedly today the most progressive medical organization in the United States. Its fame has spread far and wide, and its example is held up to the profession of a score of cities as worthy of emulation, and as an example of what can be accomplished by pluck and by unanimity of purpose. Methods and features have been introduced into its life which were entirely novel to existing societies, and that they were wisely chosen is proved as well by the phenomenal success of the Society itself as by the imitation—sincerest of all flattery—of its

methods by many other societies. As an example of the latter is first to be mentioned the new-born Cleveland Homeopathic Society, which is admittedly and ostensibly laid upon the lines which have proved so successful in the case of the older Society. Still further the Academies of Medicine in Pittsburg and Cincinnati have adopted the plan first employed by the CLEVELAND MEDICAL SOCIETY, and with such signal success, of bringing medical teachers and investigators of national renown to address the profession of the respective cities. In our own case, these meetings—three a year—have been of inestimable value to the profession in bringing together physicians who never before belonged to a medical society, and in attracting to Cleveland large numbers of physicians from the surrounding country, to say nothing of the direct benefit derived from listening to talks by the leading men of the day. So great has been the force of this attraction that at the present time not a meeting of the CLEVELAND MEDICAL SOCIETY passes without the presence of several out-of-town physicians who may have come from a distance of fifty miles, and who, first attracted by the quarterly special meetings, have been led to attend the regular meetings. This alone has done as much as any other one cause to foster the growth of Cleveland as a medical center. In no other city is to be found such a state of affairs.

With the great progress in professional spirit so well indexed by the growth and prosperity of the CLEVELAND MEDICAL SOCIETY, with new and fine hospitals, and with additional equipments for its medical schools, Cleveland's position as a center of medical thought and progress is assured, and the next few years will see this city achieve great prominence in this regard.

An additional feature of medical progress in Cleveland, and a fact of great promise for the future, is the establishment upon a secure and permanent basis of a medical library with already a nucleus of 2,000 or more volumes, and files of all the leading foreign and domestic medical journals. With a productive endowment of \$6,000 and a membership of 108 the CLEVELAND MEDICAL LIBRARY ASSOCIATION begins its second year under as favorable auspices as could possibly be wished. Its financial condition is such that with reasonable support from the profession it will take but a few years to accumulate a large and valuable medical library. The profession of this city may well be proud of its achievements in this line within so brief a time.

It has seemed desirable to many members of the CLEVELAND MEDICAL SOCIETY and to the proprietors of this JOURNAL to signalize this Centennial

year of the city by the founding of a new medical journal which shall be representative of the new spirit emphasized by the birth of the CLEVELAND MEDICAL SOCIETY. On all sides there has been for several years a demand for a medical journal in Cleveland which shall be broad in its foundations and catholic in its ideals. There has been a well-recognized need for a journal, which, imbued with the spirit of progress now so well-established, should actively work for the increasing growth of Cleveland as a center of medical progress. It has been apparent to all that such a journal could best be conducted in close connection with the spirit and organization of the CLEVELAND MEDICAL SOCIETY.

This ideal, long since conceived, has now become possible of realization, and the editors of the CLEVELAND JOURNAL OF MEDICINE take pleasure in outlining the mission which is proposed for the JOURNAL.

The connection with the CLEVELAND MEDICAL SOCIETY will at all times be as intimate as possible, with the belief that so may the interests of both SOCIETY and JOURNAL be best served. It is proposed to represent as strictly and accurately as possible the progressive spirit of the SOCIETY and to keep constantly in touch with its work, doing all that a journal can do by intelligent sympathy and active spirit to further the great work of the SOCIETY. The JOURNAL will be strictly and entirely independent of clique, faction and school, and will aim to represent the whole profession in the closest manner possible. The literary standard of the JOURNAL will be high—second to that of no American journal—and the ideals sought will be those of purest medical journalism. The contents of the JOURNAL will be scientific matter only, composed mainly of the proceedings of the SOCIETY, and a most rigid supervision of the advertisements will be maintained to keep out all undesirable firms and products. The advertising department will be retained permanently in medical hands. The Publication Committee of the SOCIETY will act in the capacity of an advisory board of editors, and will have referred to them from time to time, questions of policy in the conduct of the JOURNAL. It is the desire of the editors that this Committee should take an active interest in the JOURNAL and represent the SOCIETY in guiding by advice and counsel the course of the JOURNAL.

In conclusion it may be stated that the guiding policy of the CLEVELAND JOURNAL OF MEDICINE will be to leave nothing undone that will advance the interests of the CLEVELAND MEDICAL SOCIETY and through it the legitimate growth of Cleveland as a center of scientific medicine.



## Infant-Feeding in Cleveland

OPINIONS on the artificial feeding of infants have in the last few years made a curious circuit. The necessity for substitute feeding arises more frequently with the progress of what is called civilization; in other words, with increased social gaieties, with tight lacing, with late hours, and the consequent enfeeblement of the female digestive organs, and increased prevalence of the neurotic disposition. As a substitute for human milk nature has provided a fair imitation in the milk of domestic animals; that of the cow is, for obvious reasons, the most available; so that the question resolves itself into simply this: How can cow's milk be made most nearly to imitate human milk taken directly from the maternal founts? In answering this question it will be well to take account of the attempts which have been made and are being made in this direction.

Dilution and other alterations of cow's milk have been practiced almost ever since that substance has been used as a beverage by the very young. The diarrheas and malnutrition of bottle-fed babies, when not ascribed to Providence, have been thought to be due in the main to two causes—the formation of hard curds from the larger coagula of cow's milk and the presence of bacteria.

To avoid large coagula, dilution with either water or lime-water is efficient, but the result is a fluid of low nourishing value; as cow's milk differs from human milk in the proportionate quantity of its constituents—proteids, sugar and fat—a fair approximation to the infant's natural food can only be expected after careful analysis of mother's milk and the construction of a substance like it chemically and physically. The people who have until quite recently given the most careful attention to this subject, because it is money in their pockets, are the milk-driers. The market has been flooded with dried infants' foods, nourishing and convenient, but about as dead as pemmican. The infant that does not thrive on variously patched-up and concocted cow's milk sometimes does well on one or other of these foods. The dried food has one great advantage, bacteria thrive in it not at all. It is, however, obvious that as an imitation of breast-milk a dried food however constituted is a very imperfect copy of the original.

With the germ theory of disease came, as was thought, a release from all our troubles. The matter is simple. Milk is a good culture-medium,

and the intestine a good brood-oven. Milk, sterilized, and later pasteurized, has served an excellent purpose; but in the long run even germ-free milk will not serve, if it does not approximate fairly closely in composition to a good quality of mother's milk. Besides, there is no law of the land against finding a substitute which shall be better than the original article. Nature works by averages, and human milk varies from very poor to very good. It ought to be possible to find an artificial food equal to the better samples of the natural product. A method to be really valuable should allow a wide range of variation, to meet the indications of abnormal digestion and special diseases. The milk must, therefore, be left in its liquid condition, and so separated as to allow of its recombination to order.

The most extensive experiments of this kind have been carried on by Mr. Gordon, of Boston, in the Walker-Gordon laboratory. His method, carried out on a large scale to supply infants' food for Boston and its vicinity, begins as any effective plan must, with the source of the milk. The cows are carefully selected, tested for tuberculosis and other diseases, and their milk analyzed. The hygienic conditions surrounding them are carefully regulated, their food weighed and of the best quality and their stalls clean and dry. The milking is strictly a surgical operation, on the aseptic, not the antiseptic plan. The cow and the milker are both sterilized, especial pains being taken with the udders and the hands respectively. It is found that with the utmost precautions the first half of the milking contains a moderate number of bacteria which have found their way into the udders through the teat. The last half of the milking is practically germ-free; this is drawn directly into sterile tubes, and so taken at once to the milk-house where it is cooled to 40°F. It is then analyzed, and the cream is separated from the milk by a centrifugal machine. All the elements are then at hand for a practically germ-free food combined on prescription to meet any given indication. The milk contains mineral salts, proteids and milk-sugar, the cream contains fat, and sugar of milk, water and lime-water may be added as needed. The main difficulty with cow's milk is that the proteids are present in relatively large amount and that there is not enough of the fat and sugar. This necessitates the dilution of the milk with water, and addition of cream and milk-sugar to bring the resultant liquid up to the standard for these two ingredients.

One great advantage of this process is that a case may be studied, and its indications met by any required combination of ingredients. A prescription reads something as follows:

Fat, 3.08; Sugar, 6; Albumin, 1.01; Lime Water, 12.5; 10 feedings, 3 oz. 6dr. not heated.

This is of course a sample prescription, probably to meet some special ailment, and a study of the composition of normal milk is necessary to enable the practitioner to prescribe intelligently.

The statistics of the Walker-Gordon plant in Boston are the only ones which exist as yet to show the value of modifying milk on prescription. During four years that institution fed 2,526 infants; of these 1,518 were babies of well-to-do parents and were well cared for. Some of them were sick when they began to use the modified milk, others began it at birth. Of these 1,519 cases there were seven deaths, one from whooping-cough, two by accident, three from constitutional diseases, (it would be interesting to know what these were), one from specific disease. Among the 1,007 cases of poor children treated in tenements and in hospitals, the mortality was, in 1892  $11\frac{1}{4}\%$ , in 1893  $9\frac{1}{3}\%$  and in 1894  $4\frac{1}{4}\%$ .

The Dresden method of modifying milk is given by Dr. Worcester, in the *Boston Medical and Surgical Journal*, of September, 19, 1895. This method is founded on the fact that cow's milk contains more casein and less lactalbumin than does human milk, and on the theory that casein is less digestible than lactalbumin and therefore disagrees. The rule for imitating breast-milk is as follows: To one pint of cow's milk (of nine and one-half percent fat) add one and one-half pints of an emulsion of one egg-white and 13dr. milk-sugar in water. The milk and water used should first be sterilized, the egg should be washed first in water and then in absolute alcohol. The hands of the operator and all of the apparatus should be surgically clean. The white of egg, besides furnishing a digestible proteid makes up for the deadness of the sterilized milk. Whether white of egg is a valuable ingredient in the food of infants experience will show; it certainly seems probable enough. In case of necessity it is well to have at command a method which may be carried out by the physician or an intelligent nurse.

It is beyond question in any event that for a city of Cleveland's size a laboratory that shall furnish the component parts of milk to be combined to order has become a necessity. A glance at the mortality tables shows how pressing is the need. In 1894, an average year, 500 children under five years of age died of cholera infantum and cholera morbus; of children from five to ten years old 3, and from ten to twenty

years old 5, died of the same disease. If to the 500 deaths from intestinal diseases we add 104 from debility and 213 from inanition, two disorders which are practical synonyms for starvation, we have a grand total of 817 infants under five years old who succumbed in Cleveland for lack of proper food-supply. The number of deaths from measles, scarlet fever, diphtheria, croup and whooping-cough in children under five years of age was only 502; the deaths from typhoid all told numbered only 89, and from cancer 138. In the light of such statistics the question of purer water and better drainage sinks into insignificance; even a cure for the dread consumption would save fewer lives than proper food for infants.

A special dairy-farm for this purpose alone seems to be the only sure way of obtaining a clean and wholesome supply of milk. Cleanliness is not a barnyard virtue. Those who have noticed what many surgeons are pleased to call aseptic methods will realize the difficulties attending the cleanly extraction of milk from the udders. Poor food can not be converted into good milk. Farmers may possibly feed their cows with more care than they feed themselves, but this leaves much to be desired in the choice of food for cattle.

With the ordinary supply of dairy-milk it is necessary with many infants to use the available methods in rotation in order to avoid the cumulative effect of any one. For instance, when a child on cow's milk begins to suffer from too much bacterial action he is given one of the dried foods; when he shows signs of beginning scurvy he is put on diluted cow's milk; when this deranges his digestion the milk is peptonized. Thus he goes the rounds, always with some ailment or a threatening of one.

It has been objected to the Walker-Gordon process that it is protected by a patent or copyright on some of its features. No one need be alarmed at that in the slightest. There is probably no patent on cleaning the cow; the only embargo on that is laziness; or on giving the milker a bath before he takes his duties in hand. Cream separators have long been in use, and the addition of cream, water and other substances to skimmed milk to adapt it to infants' digestion is old and well-tried. The monopoly of such an industry is and should be enjoyed by the men who by intellect and experience are best fitted to carry it on.

It has been urged that a milk-laboratory is very expensive. This is a serious objection, and one which applies with equal force to most things which are worth having. A few cases are on record of Hindoo fathers who

have been able to nourish their children by a development of their own mammary glands. The average American parent should consider himself fortunate in the opportunity to do his duty toward his offspring by the vicarious sacrifice of his pocketbook.

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## Water and Typhoid

IN the *Lancet-Clinic* for December 14, our esteemed "T. C. M." whose views upon typhoid infection we commented upon in the *Western Reserve Medical Journal* for December, essays to confute our arguments. We regret we have not space to print this rejoinder in full. Here are the authorities he quotes to prove that typhoid infection comes from "emanations" and "exhalations": Murchison, Anstie, Austin Flint, Liebermeister and Simon; this in face of the fact, certainly well known to the medical profession outside Cincinnati, that the literature of typhoid, as a well-defined specific infectious disease whose cause is beyond all doubt a specific microorganism, is barely ten years old. What is more surprising is that not a single case of infection by sewer-gas or other emanation is marshalled, in spite of our challenge. All we get is opinions. As Murchison: "In most cases the poisons *appeared* to be contained in the volatile emanations from drains, cesspools, etc." And so with the rest; no facts are brought forward.

We are courteously referred for information to *The Index-Catalogue of the Surgeon General's Library* where typhoid "as developed by sewer-gas, milk, butter, meat, potatoes, soiled clothing, decaying timber, and even constipation and consanguinity are found to have been worthy of leading articles!" This paragraph with the following: "The editorial in the *Western Reserve Medical Journal* has much to say about the *filtration* of the London water-supply, derived from the Thames, *being rendered innocuous* by mechanical measures. This does not argue well for its *germ tendency*." (Italics ours.) We can only submit these extracts to our readers for elucidation.

Our esteemed contemporary thinks that typhoid as a factor of total mortality "hardly needs mention!"

We will present only two more quotations. In saying that typhoid is a filth-disease our contemporary concludes: "Yet there are scores of people seventy and upward who have taken only Ohio river water as a beverage for a lifetime, without being affected by the so-called bacilli of typhoid,

which only goes to prove that either some poisons are very slow or many individuals are impervious [*sic*] to so-called germs." Medical men of this part of the state need no prompting to correctly estimate the value of the above argument. Further :

"We are surprised that the *Western Reserve Medical Journal* should deny the contagion of typhoid fever, and claim that *sewer emanations* and filthy collections of excrement are incapable of developing typhoid fever. If this theory of our Cleveland friends be true, there would be no need of keeping *sewage* out of the river water." We offer a good reward to our contemporary to prove that our former editorial denied the contagion of typhoid. We specifically admitted contagion through wearing the soiled linen of a typhoid case; and contagion from stools and probably the urine, is too well-known to need mention. What we did deny was our contemporary's assertion of contagion from person to person, apart from the excreta, and we again urge him to produce a single well-authenticated case from literature of contagion by this means.

In spite of the careful and specific statement in our former editorial, of the great difference in character between the bacteria of sewage and the bacteria of the supernatant air, the *Lancet-Clinic*, in the closing paragraph above quoted, persists in inextricably confusing them. As we before pointed out clearly the bacteria of sewage are anaerobic and are never found in the air of sewers. Sewer-gas contains merely the ordinary bacteria of the air. We never denied that sewage conveyed the typhoid poison, for it is a well-established fact that it does so most frequently.

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### Cokki or Cocsi

Of medical terms probably none is more persistently mispronounced than *micrococci*. The hard sound of the second 'c' is warranted by neither authority nor analogy. The *Century Dictionary*, the best American authority, as well as one of the most liberal in matters of pronunciation gives *sī* as the sole pronunciation of the last syllable, and Gould and Foster do not give their opinion at all. One of the few rules of pronunciation fairly well adhered to in the English language, as well in words of Greek origin as in others, is that giving the soft sound to 'c' before 'e' and 'i'. *Coccyx*, *bacillus*, *vaccinate*, and many other words show this sufficiently. If the hard sound is given, let us at least spell the word with a 'k'.



## OFFICIAL PROCEEDINGS

OF THE

## Cleveland Medical Society

REGULAR MEETING DECEMBER 13, 1895

*The President, DR. WIRT, in the Chair.*

The meeting was called to order at 7:55 P. M. The minutes of the last meeting were read and approved.

The Censors reported favorably upon the application of DR. W. T. BARGER, and, on motion, he was elected to membership in the Society.

A letter was read from DR. T. W. JACKSON, signifying the wish of the Celsus Club of Akron to attend the next quarterly meeting of the Society. On motion of DR. H. S. UPSON, the Club was invited to attend the meeting to be addressed by DR. FOX of New York, on December 27th.

DR. A. F. HOUSE moved that a committee of three be appointed to arrange for the annual banquet of the Society, to be held January 10th. DR. J. E. COOK proposed to amend by giving the committee full power to arrange the details of the banquet. The motion as amended was carried. The PRESIDENT subsequently appointed DRs. H. G. SHERMAN, H. T. CLAPP and J. L. HESS to act as banquet committee.

The PRESIDENT asked for nominations for officers of the Society for the ensuing year.

DR. HUMISTON: I arise to place in nomination for President for the ensuing year, one whom you all favorably know; one who has been identified with this organization from the very beginning; one who has proved himself a capable and energetic member, and a regular attendant at these meetings. The Cleveland Medical Society does not seek to honor any man by making him President, but requires a great amount of work and time from one who accepts that office. I take great pleasure in presenting the name of DR. J. E. COOK for President for the ensuing year. The nomination was seconded by DR. HESS.

The other nominations were as follows:

First Vice-President.—DR. GEO. D. UPSON.

Second Vice-President.—DR. HOWARD S. STRAIGHT.

Recording Secretary.—DR. F. S. CLARK.

(DR. ORWIG was also nominated for Recording Secretary, but declined.)

Corresponding Secretary.—DR. G. R. FEIL.

Treasurer.—DR. F. C. TAYLOR.

Librarian.—DR. E. P. CROWE.

Censors.—DR. F. E. BUNTS, DR. J. F. HOBSON, DR. R. M. WOODWARD, DR. D. P. ALLEN, DR. R. J. WENNER.

Pathologist.—DR. W. T. HOWARD.

Trustees.—DR. O. B. CAMPBELL, DR. J. B. MCGEE, DR. W. A. KNOWLTON.

*Reported by J. S. Cadwalader, Stenographer*

## Reports of Cases and Exhibition of Specimens

DR. H. S. STRAIGHT

*Excision of the Fourth Tonsil*

I do not know that it is necessary to apologize for the size of this specimen, which is a portion of the fourth tonsil removed yesterday morning. The lingual or fourth tonsil is composed of a collection of lymphatic glands that exist normally at the base of the tongue between the circumvallate papillæ and the epiglottis. When enlarged, they project above the surface of the mucous membrane and sometimes are enlarged so much that the epiglottis is buried in this lymphoid tissue. The symptoms are fullness and a tendency to frequent swallowing, and a feeling as of a foreign body in the throat. There are hoarseness, and in singers inability to sustain prolonged effort. The enlargement of the fourth tonsil occurs most often in middle-aged women. The condition is very often associated with unatrophied adenoids. We see it in people who have a tendency to enlargement of the faucial tonsils as well. It is a matter of little consequence as regards life, but as regards comfort and the effect on the larynx, it is a matter of a good deal of importance.

DR. W. R. LINCOLN: I would like to state that in an experiment in hospital work to determine the frequency of this growth, 200 cases were observed in which the fourth tonsil, so called, occurred in about 4% of all cases presented. The growths in these instances were removed by either the cautery or the curet.

DR. A. R. BAKER: I had a case of this kind recently. When I came to remove the growth I found much more difficulty than I anticipated. I removed a small tumor a little larger than a hickorynut, and upon microscopic examination, it proved to be a fatty tumor. I do not know if this is common.

DR. STRAIGHT: I did not go into the method of removal because I did not want to take the time of the Society. The cautery is one of the well-recognized methods. I have not used the cautery myself so much as the gylotome. I had good results, and did not care to change. Sometimes I use the snare. Ordinarily the hemorrhage is insignificant. It is also recommended in good works that you use either nitrate of silver or chromic acid; but the objection to the use of any of the acids, nitrate of silver or the galvanocautery is that there is such intense soreness afterwards.

As to the size of this growth, it was only of medium size. I think that I removed all that will be necessary. Very often you can remove only part of the growth the first time. The growth does not bleed very profusely, but enough to make it difficult to control the retching. The greatest risk in the removal of the growth is in cutting away too much tissue, which interferes with the movements of the epiglottis. That is to be guarded against in the operation.

DR. D. S. HANSON

*A Case of Intestinal Obstruction*

I was called recently to see a boy seven years of age. His parents said he had been vomiting since the previous Monday, though they did not think he was very sick until the morning I was called; he had no action of

the bowels. When I saw him he was moribund, and was dead within fifteen minutes from the time I reached the house.

In making an examination, I found an obstruction about one foot above the ileocecal valve. There was a very peculiar condition. The intestine seemed to be grown right through the mesentery, and there must have been an obstruction there of very long standing. It was so very small that I could hardly see how feces passed through. On laying the gut open above the constriction, I found it filled up with a fleshy mass. The gut below the obstruction was completely collapsed. The boy was rather undersized; at the age of 7 he was not larger than a boy should be at  $4\frac{1}{2}$  or 5 years. The parents said he had complained a good deal first and last of abdominal pain, although without serious obstruction of the bowels. The obstruction was not of recent date. There was no inflammatory exudate anywhere.

DR. HUNTER ROBB

*A Case of Papilloma of the Ovary with Broad-Ligament Metastases—  
Operation—Recovery*

Mrs. A. R., aged 32, housewife, was admitted to the dispensary service of the Charity Hospital, September 11th, 1895. The family history is without significance. The patient was married twice, first when 13 years old, for 5 months; the second time for  $3\frac{1}{2}$  years. She has had two children by her second husband. Labors not instrumental. No miscarriages. Catamenia began when she was  $10\frac{1}{2}$  years old. They were always regular and without pain and lasted usually for four days.

*Present Sickness.* The exact date of the onset cannot be obtained. For the past five years she has had some pain at the menstrual period and has felt also "as though her womb were dropping out." She menstruated twice during August, for the first time, from the 5th to the 9th, and then again from the 18th to the 2nd of the month. Of late she has been complaining more particularly of pain in the right inguinal region, accompanied with backache. The intensity of the pain varies, but it is generally increased on exertion. She has leucorrhea at times. No frequency of pain on micturition. Bowels regular. No pulmonary or cardiac symptoms.

*Examination under anesthesia*, September 21, 1895. The outlet is found slightly relaxed. A tag of tissue 2 centimeters long projects from the anus. There are three patches of pigmentation on the *labia majora* and *minora*. The cervix points downwards, and shows small bilateral laceration. On the anterior lip there is an undurated mass the size of a pea. The uterus is inclined forwards, enlarged, not freely movable. On the right side, low down in the pelvic cavity, a tumor-mass the size of an orange, can be felt, slightly fluctuating, possibly an ovarian tumor. Nothing abnormal is felt on the left side; the ovary is not palpable.

On October 1st, 1895, the operation of right salpingo-oophorectomy with separation of dense adhesions, was performed at the Charity Hospital. I was assisted by Drs. Lincoln, Brokaw, Pauline Hendry, and my nurse, Miss Heriot.

The usual preparations were made. The incision, about 6 centimeters in length, was made in the median line through thick abdominal walls. The mass on the right side was as large as an orange and consisted of the tube

and ovary, and was found to be adherent to the broad ligament and to the pelvic wall. The adhesions being separated, the mass was first delivered, and afterwards transfixed, tied and incised. The left tube and ovary were so densely adherent that it was impossible to remove them, but many adhesions on this side were separated, as well as many adhesions by which the uterus was bound down to the pelvis. The abdominal cavity was then washed out with a sterilized salt-solution at a temperature of 112° F., and sponged dry. A piece of 10% iodoform-gauze was introduced into the pelvic cavity posterior to the uterus, the ends being brought out at the lower angle of the incision. The abdomen was then closed, and the usual dressings applied. The time of operation was 35 minutes. The patient made an uneventful recovery; the stitches were removed on the 7th day following the operation; there was no suppuration.

DR. ROBB showed the specimens and photographs and submitted microscopic sections, which showed that the growth had developed from the graafian follicle.

DR. W. T. HOWARD, JR.: I am much interested in this case of Dr. Robb's, as I had an opportunity of seeing the specimens in the laboratory. Dr. Robb says there are several modes of origin. They are divided into three classes, according to origin: 1. Papillomatous tumors developed in the broad ligament; 2. papillomatous tumors developed in the general epithelium; and 3, those developed in the graafian follicles. This case is a very beautiful example of papillomatous tumor developed in the graafian follicle. Besides this, it is possible for papillomatous tumors of the ovary to spring from the remains of the graafian body and from the epithelium of the fallopian tube.

As regards removal, it is rather successful even in cases of extensive secondary deposits. The operation seems to act in such cases somewhat as it does upon tubercular peritonitis.

DR. W. H. HUMISTON: This is an interesting case, and the majority of us are interested in the practical side and permanent results likely to be attained. If I understood Dr. Robb, he said the left tube and ovary were adherent, and so agglutinated that it was impossible to remove them. I believe this woman will be only partly relieved of her trouble and the operation to be complete should be one of hysterectomy. The left tube and ovary are now useless, and as the right one is removed, there would be no harm in removing the other one and the broad ligament, so as to render a recurrence of the disease more unlikely.

DR. ROBB: I would say in answer to Dr. Humiston's question that I did not know at the time of the operation that it was a papillomatous tumor. Even if I had known it I would have considered the operation more dangerous to the woman than leaving it. It would have been almost an impossible operation. And it is strange that not all these cases recur. A very large amount of evidence can be brought to show that very often in such cases the woman gets well. I cannot explain it, but it is the same way with tubercular peritonitis. If I had known at the time, I should have made an attempt to remove it. I examined quite carefully, and felt quite sure it would have been a very dangerous operation to attempt to take it out.

DR. F. E. BUNTS

*A Case of Obstruction of the Large Intestine*

There has been presented this evening a case of obstruction of the small intestine. I have here one of the large intestine. The clinical history of this case is of considerable interest, and I think, of considerable importance, from a practical standpoint.

It is very difficult, of course, in case of obstruction to determine the cause. If we knew the causes we would be more ready to operate if it were necessary, or to refrain from operating if it were not necessary. Not knowing the causes, in the majority of cases it becomes necessary to study and treat the symptoms which they present.

While this was a fatal case, I think the history is quite instructive. This man, nine days before his death, as his bowels were about to move, "felt," as he expressed it, "a sudden stop." There was no pain, and he did not consult a doctor for three days after that. He did so to get something to move his bowels. He had been troubled with chronic constipation for four years previous to that time. The doctor whom he consulted was a homeopathic physician, and gave him a diluted solution of *nux vomica*. Not obtaining a movement of the bowels, after three days of this treatment the doctor was discharged, and I was sent for. Learning the history of the case, and supposing it was from a lack of proper cathartics, the man complaining of absolutely no pain, with a pulse of about 74, no vomiting, and no history whatever to show that there was a possible impaction, I gave him a rather active cathartic in the evening. On the following morning (I think the sixth day after the stoppage of the bowels), when I went to his house, there had been no movement of the bowels, and I put him on salts and calomel. He said he thought he would sit up, and I told him I thought there was no objection to his doing so. He followed up the salts and calomel until late in the evening, when he began to vomit and had some distress, and Dr. Knowlton was called in; he lives near by. He gave him injections, which he had previously had, also without any success; and later on suggested oxgall and colocynth. On the morning of the eighth day after the obstruction I saw the patient with Dr. Knowlton, and he seemed then to show the effect of the obstruction. His pulse was 114. He had no pain. He vomited very rarely, and then only a small quantity of mucus. Realizing that he seemed to be failing for some reason, he was sent at once to the hospital, and the next morning we were to operate, in case the obstruction was not relieved. The obstruction was not relieved, and although he was nearly pulseless the following morning, we decided it was perhaps worth a trial to see if anything could be effected by an operation. Making a median incision I had no difficulty in reaching the obstruction. Now it seems phenomenal that such a small opening could allow feces to go through for four years. The lower portion of the gut is atrophied (I will pass it around in a minute), showing the effect of its disuse, and in this little box are two small foreign bodies which I found at the necropsy, wedged down against the stricture, absolutely closing it. The patient died in about half an hour after the operation.

The only lesson, perhaps, to be drawn from this is the importance of a more early consideration of operation, even in those cases of obstruction of the bowels which give no alarming symptoms. There were none in this case.

There was no pain, vomiting, or any of the ordinary symptoms pointing to obstruction, and there is no question in my mind that an early operation might have saved the patient's life.

DR. W. A. KNOWLTON: This emphasizes the fact that the physician, as well as the surgeon, should decide when it is best to go into the belly. I saw this man in the evening after Dr. Bunts saw him. He had vomited a little, and complained of distress on taking salts. His abdomen was becoming markedly distended; but the history of the case did not indicate complete obstruction of the bowel; I thought it rather indicated fecal impaction. He had not any obstinate constipation. He would go sometimes a few days without a movement, and had suffered no more inconvenience than a great many people do from constipation. Up to that evening he had had no vomiting and no fever. His pulse that evening was 100, and I concluded there was impaction. The next morning he was evidently no better, and Dr. Bunts saw the case with me, but up to that time there had been nothing in the condition of the man that I could make out to indicate an operation.

DR. HOWARD: I would ask Dr. Bunts if there was any peritonitis and if the man had septicemia.

DR. BUNTS: There was no peritonitis. I do not know whether septicemia was present or not, but there was no fever, even at the time of operation or at the time of death.

DR. L. B. TUCKERMAN: There is one feature in this case which resembles one in my own practice in the last three months. There is one point to which I shall pay a good deal more attention hereafter than I have done hitherto. If a faithful use of enemas does not produce any result, if the colon is well flushed out, I shall be more apt to suspect a serious and probably fatal obstruction of the large intestine in the next case of that kind, than I did in the last one. I was deceived by the lack of serious symptoms, and I found at the death of the patient, that there was this same condition. This obstruction was in the transverse colon. It came on gradually, and the absence of serious symptoms, until just at the end, deceived me; but there was in this case the same feature as in Dr. Bunts', that the use of injections had produced no result. I think I shall attach more importance to that feature hereafter.

DR. A. F. HOUSE

*A Case of Obstruction of the Large Intestine by Hernia through the Omentum*

As obstructions seem to be epidemic here tonight, I will report a case I lost this morning. A gentleman came from his work Saturday morning last and after eating his breakfast attempted to unlace his shoes. While attempting this he was taken with a severe pain. On trying to straighten up he found it very painful, or to sit in a straight position. The pain increased. They sent for their physician and he diagnosed neuralgia of the stomach. Three hours after the pain commenced he began to vomit, and vomited incessantly until I saw him last Tuesday evening, when he was brought to the hospital. They called in counsel, I believe, Sunday morning, and then diagnosed obstruction. He started with stercoraceous vomiting between Sunday night and Monday morning. When I saw him he was vomiting about every fifteen to twenty minutes. There was constant hiccough. The abdomen was distended so that without an anesthetic it was impossible to make out

any tumor or mass; it was very tender. After making abdominal section, it was quite a time before I could find where the obstruction was. I first got hold of the cecum, and about four to six inches above the cecum I found bands encircling the large intestine. By gradually working along I could not loosen or break the bands. By opening the wound somewhat more freely, I got the bowel and could raise it up. I found the bowel had slipped through a hole in the omentum, which had constricted it. The band was about the width of my finger, and was so firm that after releasing it it left its imprint on the bowel. The bowel was very highly inflamed, the abdominal cavity very full of fluid, and about fifteen minutes after releasing the stricture there was a passing of gas and some small quantity of fluid. He did not have any movement then until Wednesday evening. By using a rectal tube about a pint of fluid passed from the bowel. Yesterday he had, I think, four or five large stools. He died this morning.

DR. HANSON: In looking over the histories of some of these cases I saw some statistics collected by Robinson, of New York, in which he stated that from 60% to 70% of these cases were in the sigmoid flexure of the colon. If that is a fact, I think it would be a diagnostic point of some value that very little fluid could be injected into the bowel. It may be a very important point for us to remember in making a diagnosis of those cases.

DR. TUCKERMAN: I wish to call attention to some recent investigations. I think Dr. Murphy, of Chicago, called attention to the fact that after the bowels have been obstructed and fermentation has taken place in the small intestine, movement of the bowels is very often followed by fatal collapse, due to absorption of ptomains already formed in the bowel. He gives a number of instances.

DR. HOUSE: I would say that after the patient had recovered from the anesthetic, I used a gallon of warm water at about 110°. He had not been able to retain a particle of fluid from the time he was taken sick last Saturday morning. I gave him about a half-gallon, which he retained, and the volume of the pulse seemed to pick up, and the pulse dropped about 8 beats per minute after using the hot water. On Wednesday I used another enema of half a gallon. No pain was caused by it.

## Program

DR. DUDLEY P. ALLEN

### *The Influence of Anesthetics upon Temperature*

This was an unusually interesting paper. As the observations are not yet complete publication has been deferred.

DR. ROBB: Dr. Allen's paper is a very valuable one, and I congratulate him upon it. I had occasion some months ago to look up the literature of anesthetics, and I remember there were some experiments which had been made as far back as 1848, in which it was demonstrated very conclusively that the temperature is always very much lowered in anesthesia. I remember this statement also by another author. Some work was done in Germany in which are considered very carefully the effects of alcohol, chloroform and ether upon the temperature in animals, and in all instances it was very much reduced. I do not remember the details of the experiments, but those were the results. We must keep our patients thoroughly protected and warm, so that they will not be exposed to these dangers.

DR. BUNTS: I do not remember just the number of cases in which the doctor mentioned increase of temperature due to the use of hot bottles, wraps, etc., but the question naturally arises, at least it occurs in my mind, whether the increase in temperature is advantageous, or is equally disadvantageous with the reduction of temperature; whether there is not the same harm done by raising the temperature too high, as by allowing it to fall below the normal. The experiments seem to show that in some cases it does rise several degrees above the normal temperature, and it may be a disadvantage as much as having the temperature below the normal.

DR. TUCKERMAN: The Doctor was speaking of some of those European operators apparently paying no attention to the matter of heat or cold. I have seen it stated somewhere, I do not remember the author, that there is among Europeans generally, especially among the peasantry, very much less sensitiveness to cold than there is with us, and the question arises whether that carelessness is not a result of their experience. It would be carelessness here, but is it carelessness there?

DR. ALLEN: I will simply answer the questions asked. In reference to what Dr. Bunts said of increasing the temperature, I did not mean to be understood to say that it was a desirable thing to increase the temperature, but simply made the experiments to show that in spite of amputation and bleeding you could increase the temperature by means at hand by covering and using heat. In reference to what Dr. Tuckerman said, I think there must be something in it. These people live in rooms much cooler than ours. If you notice patients walking about the wards of German hospitals, you will see they have only little jackets around them, and they will be out in what we would call pretty cool weather. I am sure I have seen many patients upon the German operating table recover from an operation from which an American would have died, because they were operated on in a degree of cold that would have proved fatal.

### Northwestern Ohio Medical Association

The fifty-first annual meeting of this society occurred at Findlay December 12th and 13th. The attendance was quite large, nearly 100 physicians being present. The President, Dr. J. K. Woods, of Van Wert, presided. The session opened shortly after 4 P. M. December 12th with prayer by Rev. S. E. Greenawalt. Mayor Nemeyer of Findlay welcomed the Association in a happy address. Dr. M. M. Carrothers, in behalf of the Hancock County Medical Society, welcomed the visiting physicians. He discussed the unhappy situation of the medical profession in the State of Ohio, and alluded to the election of a member of the Hancock County Medical Society—Dr. J. A. Kimmel—to the legislature, expressing the belief that much good to the profession would result therefrom.

Drs. Frank Winders, Norman L. McLachlan, Jacob E. Powell, and J. A. Kimmel, of Findlay, and Dr. John S. Windisch, of Port Clinton, were elected members.

The annual election of officers was postponed to the next morning. Considerable discussion took place in regard to the use of a name similar to that of the Association by an Eclectic society, but no action was taken.

The first paper, by Dr. Joseph Sager, of Celina, was then read. His subject was "Affections of the Lachrymal Ducts." The paper was discussed by Drs. X. C. Scott, Lanman, Steiner, Vail, Martin, Beardsley, and Hixon.



The next paper read was "Psychological Philosophy," by Dr. Shelby Mumaugh, of Lima. The author urged physicians to pay more attention to mental influences. The paper was discussed by Drs. Hubbard of Toledo, Beardsley of Ottawa, Stamm of Fremont, and Hoffer of Lima.

The meeting then adjourned till evening.

The evening session was opened by a paper upon "The Treatment of Tuberculosis," by Dr. J. C. Culbertson, of Cincinnati. The author inclined to a belief in the ordinary curability of the disease under favorable conditions. The following gentlemen discussed the paper at length: Drs. Thorne of Toledo; Caldwell of Fremont, Hubbard of Toledo, and McClasky of Fort Wayne.

Dr. J. C. Culbertson, of Cincinnati, and Dr. W. H. Myers, of Fort Wayne, were elected honorary members of the Society.

Dr. G. W. McClasky, of Fort Wayne, reported "A Case of Successful Localization of Intracranial Hemorrhage," which proved very interesting.

Dr. J. C. Oliver, of Cincinnati, followed with a paper upon "Skin Grafting after the Method of Thiersch," reporting some successful cases. In the discussion Dr. Hofer of Lima reported a case of severe burn of the legs, in which  $4\frac{1}{2}$  square feet of skin were grafted upon the limbs. This required 1,200 pieces of skin. Drs. Ellis of Dayton, and Steiner of Lima also discussed the paper.

Dr. Hamilton, of Columbus, read a paper upon "A Case of Stone in the Kidney," which was discussed by Drs. Stamm of Fremont, Hiner of Lima, Ellis of Dayton, and McClasky of Fort Wayne.

Upon invitation of Dr. P. J. Baker the Association then adjourned to a banquet at the Jay House, given by the Hancock County Medical Society.

In consideration of the feelings of those members who could not attend the *menu* will be omitted. After the viands had been properly cared for, Dr. F. W. Firmin, as toastmaster, very happily opened the speech-making portion of the program. Dr. S. B. Hiner, of Lima, eulogized "The Northwestern Ohio Medical Association." Dr. J. A. Kimmel paid his respects to the "Hancock County Medical Society." Rev. S. E. Greenawalt spoke very pleasantly of "The Relation of the Minister and the Physician." Col. J. A. Bope grew eloquent upon "The Legal and Medical Professions." Dr. J. C. Culbertson spoke vigorously upon "Medical Legislation." Dr. X. C. Scott responded to the toast, "The Progressive Physician." Mr. C. W. Bente, editor of a Findlay paper, gave his views upon "Non-Advertising vs. Advertising Doctors." The program closed with a toast from Dr. J. C. Martin upon "From Catnip and Tansy to Tuberculin and Antitoxin."

The morning session upon Friday opened at 9 A. M. with an exhaustive paper by Dr. Thomas Hubbard, of Toledo, upon "Clinical Notes on Certain Nervous Affections of the Throat." Dr. C. J. Aldrich, of Cleveland, followed with a paper upon "Autointoxication as a Cause of Nervous Disease." Dr. C. A. Hamann, of Cleveland, read a paper, "Some Points in the Surgery of Nerves." Dr. W. H. Myers, of Fort Wayne, read a paper entitled "Adynamic Intestinal Obstruction." Dr. N. Stone Scott, of Cleveland, reported a very interesting "Case of Enteroplasty."

The annual election of officers, which followed, resulted in the election of Dr. Charles Graefe, of Sandusky, President; Dr. Charles Slocombe, of Defiance, Vice President; Dr. J. A. Baker, of Findlay, Secretary, and Dr. T. M. Gehrett, of Deshler, Treasurer.

Dr. F. W. Entrikin was elected a member.

The closing number was a paper upon "The Local Treatment of Diseases of the Air-Passages," by Dr. Charles Graefe, of Sandusky.

No afternoon session was held, as a number of physicians upon the program were unable to be in attendance.

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### Book-Reviews

**PREGNANCY, LABOR, AND THE PUERPERAL STATE.**—By Egbert H. Grandin, M. D., Consulting Surgeon to the New York Maternity Hospital; Consulting Gynecologist to the French Hospital, New York, etc.; and George W. Jarman, M. D., Obstetric Surgeon to the New York Maternity Hospital; Gynecologist to the Cancer Hospital, New York, etc. Illustrated with forty-one (41) original full-page photographic plates from Nature. Royal octavo, pages viii, 261. Cloth, \$2.50 net. Philadelphia: The F. A. Davis Co., Publishers, 1914 and 1916 Cherry St.

This book treats successively, in three parts, the three subjects indicated in its title. The plan of the author is not to give an exhaustive treatise, but to make the book a reliable source of information for the practitioner and a text-book for students. It is better adapted for the former than for the latter, though in offering it for students it has been with the supposition that the subjects of "anatomy, physiology, embryology and pathology" have been thoroughly studied in their respective departments. For this reason these subjects receive little attention. It is, however, very probable that the student will not appreciate the relations of these four subjects as thoroughly as if they were all combined in one work.

The book is well illustrated, many of the cuts being new and valuable. Others show little else than the large number of assistants who rather overshadow whatever else the cut is intended to show.

The authors are to be commended for the attention they advise to be given to the pregnant woman before labor begins, especially regarding the use of the pelvimeter and abdominal palpation.

Part second is devoted to labor, beginning with its mechanism and taking up its course in normal and abnormal cases, together with the immediate care of the newborn.

The method of protecting the perineum by attending more to the advancement of the head than to efforts to support the perineum, is worthy of careful consideration, but to aid the delivery of the head with one or two fingers in the rectum can hardly be commended. There would be too great danger, especially in the event of some sudden emergency, of introducing those fingers into the birth-canal before they had been thoroughly cleaned, and undoing in a moment all good results of care in asepsis and antiseptis, so strongly and well insisted upon previously.

Following the discussion of the normal puerperal state, there is a consideration of the varieties of puerperal infection and their treatment. From the nature of the book this cannot be exhaustive, but gives one the clinical facts, as he sees them in his cases. This, also appearing in other parts, adds much to its value as a reference book.

F. S. C.

**PRACTICAL URANALYSIS AND URINARY DIAGNOSIS.**—A manual for the use of Physicians, Surgeons and Students. By Charles W. Purdy, M. D., Queen's University; Fellow of the Royal College of Physicians and Surgeons, Kingston; Professor of Urology and Urinary Diagnosis at the Chicago Post Graduate Medical School; Author of "Bright's Disease and Allied Affections of the Kidneys;" also of "Diabetes: Its Causes, Symptoms and Treatment." Second revised edition. With numerous illustrations, including photo-engravings and colored plates. In one crown octavo volume, 360 pages, in extra cloth, \$2.50 net. Philadelphia: The F. A. Davis Company, Publishers, 1914 and 1916 Cherry St.

The second edition of this excellent hand-book reaches us, laboring still under its barbarous title—"Uranalysis." The *Medical News* of November 23, 1895, disposes, finally, it seems to us, of this "neoplasm," as follows: "In writing to Dr. W. W. Skeat, of Cambridge, England, the undisputed master of English etymology, the author of the great etymologic dictionary, we incidentally mentioned the coinage of the word '*uranalysis*,' and asked him what he thought of it. His characteristic reply was, 'I need only say that *uranalysis* means analysis of ure; whatever ure means I do not know.'"

In the preface of the same edition of this book, which we wish to state is, in our opinion, one of the very best of its kind, the author says, "The very generous reception given the work by the medical press and profession, and its early adoption as a text-book by a large number of medical schools and colleges, have induced the author to *thoroughly revise* the work, to *correct all discovered errors*, and to further illustrate the text by additional colored plates." The italics are ours. In a review\* of the first edition of this work we took occasion to point out several errors in statement and in rhetoric. An examination of this second edition shows that, for the most part, the errors are just where they were in the former edition. Fehling's test for glucose is condemned because the reagent will not keep—no mention is made of the ready and efficient expedient of keeping it in two portions. Rosin's test for bile, a good one, is not yet mentioned. Herter's work on uric acid is yet ignored. Kelly's work on bladder exploration is not recognized. On pages 138, 181, 194, 204 and 213 occur errors in grammar, specified in our former review, which are inexcusable in a revised edition.

These deficiencies detract in no way, however, from the definiteness of our opinion, gained from a somewhat extended use of the work, that this book is the most generally useful one upon the examination of the urine which has so far fallen into our hands.

P. M. F.

**MATERIA MEDICA AND THERAPEUTICS.**—A practical treatise with especial reference to the clinical application of Drugs. By John V. Shoemaker, A. M., M. D., LL. D., Professor of Materia Medica, Pharmacology, Therapeutics, and Clinical Medicine, and Clinical Professor of Diseases of the Skin in the Medico-Chirurgical College of Philadelphia; Physician to the Medico-Chirurgical Hospital, Philadelphia, etc., etc. Third edition, thoroughly revised. Reset with new type and printed from

\*WESTERN RESERVE MEDICAL JOURNAL, Vol. III, p. 337, *et seq.*, May, 1895

new electrotpe plates. Royal octavo, pages ix, 1108. Extra cloth, \$5.00 net; sheep, \$5.75 net. Philadelphia: The F. A. Davis Co., Publishers, 1914 and 1916 Cherry St.

This work gives a very complete account of remedial measures, including not only drugs but more impalpable agents, such as electricity, magnetism, hypnotism, and even music. In fact, it might possibly improve the book to exercise a little more discrimination in weeding out many resources of the healing art not proven to be of any value. The tone of the book is decidedly optimistic. A critical view, for instance, of the subjects of animal extracts would result in the separation of such substances as cerebrin, cardein and the like from thyroid extract and the antitoxin of diphtheria. The recent somewhat pessimistic views of several authorities on the value of electricity as a curative agent are hardly in accord with the section devoted to that subject in this work. The chapter on hypnotism is very fair and well-written, and while the book errs, if at all, in taking too rosy a view of many measures which have seemed failures to others, it may possibly serve as a correction to a pessimism which, if carried too far, is certainly destructive to vigor of thought.

H. S. U.

CLINICAL LECTURES ON DISEASES OF THE NERVOUS SYSTEM, DELIVERED AT THE NATIONAL HOSPITAL FOR THE PARALYZED AND EPILEPTIC, LONDON.—By W. R. Gowers, M. D., F. R. S., Physician to the Hospital, Consulting Physician to the University College Hospital, Formerly Professor of Clinical Medicine in University College, Philadelphia. P. Blakiston, Son & Co., 1012 Walnut Street, 1895, 279 pages, octavo.

This new work by Gowers carries with it such instruction as may be given to advanced students or recent graduates in medicine. None of the essays is in any sense monographic, but with an easy, colloquial style, cases are given emphasizing certain points in diagnosis. The writer brings to his work not only a philosophic mind, but a good corrective of the faults which sometimes go with it, in a keen power of observation which keeps him from the error of generalizing on incomplete data. Gowers' systematic work on nervous diseases is too well known to require comment. The present work fills an entirely different place, as it may be read by the busiest practitioner when systematic reading is out of the question. The publishers' work is in the main well done. The binding of the book is attractive. Indeed it were a pity to dress such pleasant matter in dry pigskin. The paper and print are good. Not so much can be said for the proof-reading, which might have been better done if the writer had been nearer at hand. Such mistakes as "emphasise," page 42, "sensories" for senses, page 41, and others of like kind, are venial offences and do not detract much from the value of the book. The work is a valuable one to those who do not wish to confine themselves to dusty books of reference.

H. S. U.

## Books and Pamphlets Received

- SPECTACLES AND EYEGLASSES, THEIR FORMS, MOUNTING AND PROPER ADJUSTMENT**, by R. J. Phillips, M. D., Adjunct Professor of Diseases of the Eye, Philadelphia Polyclinic and College for Graduates in Medicine; Ophthalmic Surgeon to the Presbyterian Hospital in Philadelphia, etc. Second edition. Revised, with forty-nine illustrations. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut Street, 1895. \$1.00.
- A GUIDE TO THE EXAMINATION OF URINE FOR THE USE OF PHYSICIANS AND STUDENTS**, by James Tyson, M. D., Professor of Clinical Medicine in the University of Pennsylvania, and Physician to the Hospital of the University; Physician to the Philadelphia Hospital; Fellow of the College of Physicians of Philadelphia, etc., etc., etc. Ninth edition. Revised and corrected. With a colored plate and wood engravings. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut Street. 1895. \$1.25.
- HANDBOOK OF THE DIAGNOSIS AND TREATMENT OF SKIN DISEASES**, by Arthur Van Harlingen, Ph. B., (Yale) M. D., Emeritus Professor of Dermatology in the Philadelphia Polyclinic; Dermatologist to the Howard Hospital. Third edition, enlarged and revised. With sixty illustrations, several of which are colors. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut Street. 1895. \$2.75.
- OUTLINES OF MATERIA MEDICA AND PHARMACOLOGY. A TEXT-BOOK FOR STUDENTS**, by H. M. Bracken, M. D., Professor of Materia Medica, Therapeutics and Clinical Medicine, University of Minnesota. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut Street. 1895. \$2.75.
- MANUAL OF GYNECOLOGY**, by Henry T. Byford, M. D., Professor of Gynecology and Clinical Gynecology in the College of Physicians and Surgeons of Chicago; Professor of Clinical Gynecology in the Woman's Medical School of Chicago. Containing two hundred and thirty-four illustrations, many of which are original. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut Street. 1895. \$2.50.
- DIPHTHERIA AND ITS ASSOCIATES**, by Lennox Browne, F. R. C. S. Ed., Senior Surgeon to the Central Throat, Nose and Ear Hospital; late President of the British Laryngological Association; Corresponding Fellow of the American Laryngological Association; author of "The Throat and Nose, and their Diseases," etc., etc. Illustrated by the author. London: Baillière, Tindall & Cox. Philadelphia: J. B. Lippincott Company. 1895.
- CLINICAL LECTURES ON DISEASES OF THE NERVOUS SYSTEM DELIVERED AT THE NATIONAL HOSPITAL FOR THE PARALYZED AND EPILEPTIC, LONDON**, by W. R. Gowers, M. D., F. S. Physician to the Hospital, Consulting Physician to the University College Hospital, formerly Professor of Clinical Medicine in University College. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut Street. 1895. 279 pages octavo.
- INSANITY AND PHTHISIS, THEIR TRANSMUTATION, CONCURRENCE AND COEXISTENCE**, by A. O. Tomlinson, M. D., St. Peter, Minn.  
Reprint from *Journal of Nervous and Mental Diseases*, October, 1895.

## Are Alcoholic Stimulants a Benefit in the Treatment of Disease?

MICHIGAN CITY, IND., December 3, 1895

*Editor Cleveland Journal of Medicine :*

Dear Sir : Some thirteen years ago, at Braidwood, Ill., during a small-pox epidemic, eighteen cases out of twenty-two who had been addicted to the use of alcoholic stimulants, died, while nearly every case of temperate habits, where no stimulants were used in the treatment, recovered.

Three years ago at Chesterton, Ind., where I was then practicing medicine, during the grip, nearly one-half of all cases where stimulants of any kind were employed in treatment, died, while nearly every case where no alcoholic stimulants were used, made good recoveries.

From these and other similar cases, with unfavorable results from the use of any intoxicating stimulants in the treatment of disease, I sincerely believe that an intoxicating drug used either in sickness or health has done a thousand times more injury than good.

The common custom of mothers and nurses of administering small quantities of *cognac* or other intoxicating liquors, is a crime, and ought to be prohibited and punished by law, for it is forcing the appetite for strong drink on these little ones, against their knowledge and will. I am for prohibiting the cause.

W. H. GRAY, M. D.

## German Reports on Antitoxin

The Ministry of Medicinal Affairs of Berlin has just published (November, 1895,) the statistics gathered from an extended and thorough investigation into the results of the serum treatment of diphtheria.

Letters of inquiry were directed to physicians throughout Germany and answers were received dealing with 6,626 cases, the mortality being 12.9 percent. 2,460 of these cases were treated in hospitals, with a mortality of 19.5 percent. Opinions were expressed in 4,871 cases. In 55.6 percent of them the remedial effect of the serum was characterized as certain, 30.8 percent as probable, and 13.6 percent as producing absolutely no effect. In 4,544 cases the serum treatment was described as perfectly harmless. In 60 cases it proved injurious, and of these, 42 recovered and 18 died. In these 60 cases the patients suffered from skin eruptions, nephritis, and albuminuria, disturbance of the heart's action, pains in the joints and general debility.

It was the judgment of the committee that the serum was not altogether responsible for all of these complications, and that its continued use was justified.

H. J. HERRICK, JR., M. D.

## The Annual Meeting and Banquet

The annual meeting of the Cleveland Medical Society, with election of officers for the ensuing year and reports of the retiring officers, will be held in the rooms of the Chamber of Commerce, January 10, at 7:30 p. m., sharp.

The Society will adjourn to the Hotel Hollenden for the annual banquet at 8 p. m. The committee has made arrangements for a good dinner at moderate cost, and for an unusually interesting program of toasts. It is the intention to make this the best banquet the Society has ever held and all are urged to attend. There will be nothing dry upon the program but the toasts, and nothing heavy but the salads. Medicine is to be relegated to other realms, and the ladies are to be invited to share in the general good-fellowship which it is intended to make the main feature of the evening.

Come and bring your friends, and enjoy an evening of rare entertainment, leaving behind the dull cares of life.

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## American Medical Review

It is a pleasure to welcome in the field of medical journalism so novel and so worthy a publication as the *American Medical Review*, the first number of which was published in December. Its purpose is to give such a monthly review of current American medical literature as does the *Review of Reviews* of general literature. This number indicates that the work is in capable hands. There are 64 pages of reading matter. These include abstracts of 50 leading papers in the various journals. There are also society proceedings, miscellaneous notes and abstracts, personals, original interviews and articles, and book-reviews, and lastly, a tabular reference-index of the leading articles in the current American journals. The *Review* is edited by Daniel Lewis, M. D., and published by The R. N. Plummer Company, 106-8 Fulton Street, New York, at \$1.00 a year.

Such a journal as this *Medical Review* is new in the field of medical literature and fills a decided need. Reviews in the general medical journals are necessarily incomplete. They are very difficult to classify, and seem, most of them, out of place. It will be the definite policy of this JOURNAL to publish few if any abstracts, as our space is fully occupied by original work. We are, therefore, glad that our JOURNAL may be supplemented in such a satisfactory way.

It certainly seems that such a publication should very readily be an unqualified success and the *Review* is to be congratulated upon the excellent appearance of its initial number.

The *Review* will be sent free during 1896 to new subscribers to the JOURNAL who so request; thus for the price of the JOURNAL alone our subscribers will receive a good local journal and a complete monthly review of current American medical literature.

# Cleveland Journal of Medicine

VOL. I

FEBRUARY, 1896

No. 2

## A Case of Enteroplasty

BY N. STONE SCOTT, A. M., M. D., CLEVELAND, O.

*Professor of Genito-Urinary Diseases and Regional Anatomy, University of Wooster;  
Consulting Surgeon to the Cleveland City Hospital; Visiting Surgeon to  
St. John's Hospital; Surgeon to the Out-Patient Department  
Cleveland General Hospital; &c.*

THERE are few diseases so liable to furnish a wide range of complications and tax the ingenuity and skill of the operating surgeon as intestinal obstruction. The case which I report today illustrates two conditions liable to be present in acute intestinal obstruction, and as their relief required the operation of enteroplasty, I will briefly consider them.

The first is: How shall we deal with the over-distended, paralyzed intestine and its contents?

I have a vivid remembrance of the mental and physical anguish of one of my instructors some years ago in his endeavor, as was the custom at that time, to return to the abdomen an intestine whose contents were sufficient to fill a much larger cavity. Some two years ago I operated for acute intestinal obstruction of five days' standing. The patient's condition was good, the obstruction, which proved to be a knuckle of intestine in an old femoral hernia, was easily overcome and the patient ought apparently to have recovered. Nevertheless, he died two days later, and at the necropsy everything was in perfect order except the enormously distended intestine.

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*Read before the Northwestern Ohio Medical Society at Findlay, December, 1895*



This I believe to have been the cause of death. In a case of intestinal obstruction the severity of the symptoms bears a direct ratio to the amount of distension of the intestine. The over-distended condition of the alimentary tract should be relieved at the time of operation by puncturing the bowel in one or more places, as may be necessary, with a medium-sized trocar, or by making incisions into the bowel sufficiently large to thoroughly empty the bowel of the liquid feces and gas. The apertures caused by the trocar or incision are closed by one or two stitches. At the same time it is well to introduce through the mouth a stomach-tube and withdraw the gas from that viscus, if it is distended. Such treatment should be sufficiently thorough to allow the bowel to collapse. This method, assisted by liberal doses of strychnin given after the operation, gives the over-stretched and paralyzed circular fibers a chance to regain control of the bowel. It requires no mathematic demonstration to prove that such a collapsed intestine can be more easily replaced in the abdomen than the same intestine over-stretched by gas.

The second complication is the cicatrix of the bowel, the result of the inflammation at the site of an old adhesion. It goes without saying that the obstruction must be relieved, else the patient is doomed. Such intestinal adhesions, as a rule, do not encroach upon the lumen of the intestine, but by fixing the intestine and interfering with its free motion favor the kinking of the intestine with the development of symptoms of intestinal obstruction. Such adhesions are comparatively easily relieved, but if the cicatrix is so extensive that the lumen of the intestine is decidedly encroached upon, it will frequently happen that the intestine will be opened in freeing the adhesion and something will have to be done to repair the loss of continuity. Even in such a case a resection of the entire lumen will rarely be necessary to give a useful caliber to the bowel. A diamond-shaped piece should be removed, including the old cicatrix, or the cicatrix and opening into the bowel. This is then sewed up, with Lembert-Czerny stitch, in such a way that the row of stitches is transverse to the long axis of the bowel.

In illustration of the above, allow me to detail the following case:

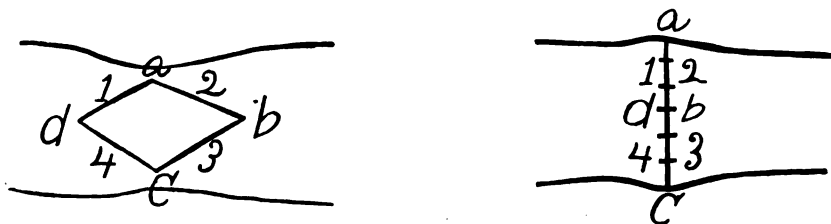
Mrs. M—, aged 28 years, married seven years. Six months after marriage she was operated upon for some pelvic trouble, but has not been very well since. A year ago she consulted eminent specialists in Europe, but without success. Since her return my friend, Dr. Nydegger, who referred the case to me for operation, has been treating her, with some relief, until her present acute attack. Sunday, November 10, 1895, she had four passages of a diarrheal character, but nothing had passed since up to the time I saw her, at 4 P. M., Friday, November 15, 1895, a period of five days. At this time she was under the influence of morphin, which had been necessary for the pain of the preceding thirty-six hours. She was vomiting fre-

quently, but without great effort, although the vomited material was not as yet distinctly fecal. It was apparently the contents of the duodenum. The bowels were quite bloated. An immediate operation was advised, and she was removed to the hospital. I operated the same evening by gas-light, with the assistance of Drs. Nydegger, Kaestlen and Buel, and Mr. Ashley, a student.

On opening the abdomen a considerable quantity of amber-colored fluid escaped together with the distended bowel. A loop of jejunum was found partially obstructed by a band which held it to the brim of the pelvis. This was ligated and cut. Two inches above this point of adhesion the intestine was so distended that the peritoneum was already ruptured for a distance of about three centimeters, extending in the long axis of the intestine. Two stitches were taken here to prevent farther damage. Just below this point two loops of intestine were bound together by a broad band which was incised and the examination continued.

A loop of the ileum was found firmly adherent behind the uterus to the floor of Douglas' culdesac. Here was the point of obstruction, as, beyond this, the intestine was collapsed. So firm was the adhesion that it was necessary to make use of the scissors; but as it was necessary to work entirely by the sense of feeling in dense cicatricial tissue, an opening was made in the intestine. On examining the intestine it was found that there was not only a hole in the gut, but that the cicatricial contraction had at this point narrowed the lumen of the intestine to less than half its normal caliber. Simply to have sewed up the laceration would have left an almost complete obliteration of the lumen of the intestine.

A plastic operation was, therefore, performed, in order to close the opening and restore the lumen of the intestine. A diamond-shaped piece was excised, with the borders an inch in length; this included the old cicatrix with the laceration. A double row of stitches was then placed in such a way as to be transverse to the lumen of the intestine. This was done in the following manner:



Refer a moment to the accompanying chart, the left hand figure of which illustrates the intestine with the line of incision, while the right hand one shows the method of approximation in the restored intestinal lumen. The angles *a* and *c* were retracted by two tenaculums, bringing the angles *b* and *d* to-

gether. The side 1 was united to 2, and 3 to 4, by two rows of stitches; the first row was of catgut, a continuous suture uniting mucous membrane to mucous membrane. The second row was of silk of interrupted stitches and united peritoneum to peritoneum.

In looking over the intestine after completing the first enteroplasty, it was found that the two stitches placed at the site of the lacerated peritoneum had torn out; they were, therefore, excised, including the whole thickness of the intestine and the gas and liquid contents allowed to escape. In order to close this opening a second less extensive enteroplasty was made in the same manner as the first. The intestine was thoroughly washed, the abdomen flushed and drainage established through the vagina. The abdominal incision was closed. The patient came off the table with a pulse of 150, but the next day was feeling so well that the nurse was obliged to request her for her own good not to sing.

Hypodermics of strychnin, gr.  $\frac{1}{16}$ , were administered every two hours and nutritive stimulating enemas every four hours. She passed flatus the next morning at 10:30 A. M., and went on to an uninterrupted recovery.

Not the least interesting point of this case is found in the fact that a vaginal examination at the present time shows an entire relief from her former pelvic trouble, which proves that her pains, from which she suffered seven years and for the relief of which she went to Europe, were caused by the intestinal adhesion.

While one case is not enough from which to draw general deductions, it may illustrate certain points. The especial features of this case are:

- 1st. The satisfactory results obtained by thoroughly evacuating the intestine by free incisions.
- 2d. The restoration of the normal lumen of the intestine by a plastic operation.
- 3d. The relief of the chronic pelvic trouble by the freeing of the intestinal adhesion.

*531 Prospect Street*

## Empyema of the Maxillary Sinus

BY C. P. AMBLER, M. D., CANTON, O.

*Formerly Laryngologist and Rhinologist to Winyah Sanitarium, Asheville, N. C.*

OF all the catarrhal diseases involving the upper respiratory tract, probably no one is more often improperly diagnosed and treated than those complicating the accessory nasal sinuses.

The fact is often overlooked that the discharge from the nose only indicates that the nares are being used as a sewer to drain a cavity accessory

*Read before the Stark County Academy of Medicine, Nov. 6, 1895*

to the nasal passages proper. It is not a difficult matter to determine that the discharge comes from a sinus, but to determine *which* sinus and whether one or more is involved, is a difficult matter indeed.

The symptoms of suppurative disease of the antrum are similar to the symptoms present in suppuration of the other nasal sinuses and what we have to say of the antrum in regard to etiology and treatment in general holds true with the frontal, ethmoidal and sphenoidal sinuses also.

**ETIOLOGY**—Suppurative disease of the antrum can generally be traced to one of two causes: an obstructing nasal disease or traumatism of the antrum-wall.

A simple catarrhal inflammation of the sinus is a frequent complication of a common cold in the head; the stenosis being temporary, resolution is the result. If there is chronic stenosis of the nasal passage, resolution will be retarded and the secretion retained in the sinus will undergo suppurative changes. If the normal outlet is not free at this time, pressure and pain follow, and when the pressure becomes so great that the discharge takes place, we get the bright yellow, cleanly looking pus, characteristic of sinus inflammation.

If the cavity from now on has free drainage, even if suppuration has occurred, the same in a few days may disappear spontaneously, but if the nasal conditions are such as to retard the flow, if the subject is anemic and poorly nourished, the contrary may result and we have a chronic catarrhal inflammation of the cavity or cavities involved.

Moderate stenosis is the most fruitful cause of postnasal catarrh, especially when the cavity in question is the maxillary sinus. When the case becomes chronic one of two changes is probable: viz., degenerative change of the mucous membrane with polypoid or granulation-tissue formation, or the retention of the more solid part of the secretion, forming a semi-solid putrid debris of a mealy appearance and disgustingly offensive. In either case the delicate membrane may become ulcerated, the periosteum involved and necrosis result.

The position of the normal outlet of the antrum and of the sphenoidal sinus favors retention, from the fact that the opening is situated, not at the most dependent part, but high up in the lateral wall.

Antral disease develops in comparatively few cases of chronic atrophic rhinitis. Where due to nasal disease it is generally associated with or follows some condition causing stenosis. It has been claimed that it is merely an extension of the inflammation from the nasal passages. When we consider that inflammation shows a hesitancy in extending from one anatomic region to another, this seems hardly probable.

It is doubtful if the nares can be occluded with polypi without some antrum complications.

Traumatism, generally the extraction of teeth, plays an important part in the etiology of antrum empyema.

The first two molars frequently project into the antrum, the root being covered by but a thin plate of bone; this becomes injured as the teeth are extracted and the small pieces or spicules of bone undergo necrosis, starting up a persistent discharge of pus from the antrum into the nares.

J. A. Wyeth, (*Medical Record*, Dec. 8, 1883,) reported a case in which a supernumerary tooth developed in the antrum and acted as a foreign body, causing suppuration with recovery only after operation.

Dr. Wm. Carr read a paper before the New York Medical Society, Oct. 15, 1895, (*Medical Record*, Oct. 26th,) upon this subject in which he claims that 80% of antral cases occurring in his practice were caused by either caries of the teeth or injury to the antral wall during extraction. When you consider that but a comparatively small number of cases have teeth which penetrate the antrum, this appears as a remarkable statement.

In the catarrhal form the mucous membrane is hyperemic from the first, and as the membrane and walls of the blood-vessels are extremely thin, slight hemorrhages take place. The mucous membrane becomes greatly swollen and exudes a bloody serum, more or less of which finds its way into the nostril. This stage may last but a few days or may run along for months. Finally, however, the discharge gives way to one of pure laudable pus of a bright yellow color. Periostitis, followed by bone proliferation results in spicules and plates or ridges of bone, which may become so marked as to form partition-walls dividing the antrum into two or more cavities.

**SYMPTOMS**—The symptoms of empyema of the antrum are always vague and differ in each individual case. If the serous bloody effusion of the acute state does not find vent, pain comes on early. Later, tenderness and swelling over the cheek occur; the teeth appear to be elongated and are sensitive. If evacuation does not now occur the pain becomes excruciating and demands prompt surgical interference. This, however, is not usually necessary. If the normal opening remains obstructed and the secretions go on accumulating, the weaker walls of the cavity bulge, perhaps perforate, and the pus finds its way through the thin external wall and cheek or through the orbital plate.

If evacuation occurs through the natural opening, the discharge comes away for a day or two, then for some cause or other the obstruction becomes greater and the same experience is gone through with again. As a rule, the discharge is greatest during the morning, in many cases ceasing entirely after the middle of the day. The discharge invariably has a musty, graveyard odor, but never excites inflammation of the nasal passages. The quantity of the secretion is so great that crust-formation is impossible.

The sinus discharge of the early stage frequently finds its way into the pharynx, while after suppuration the pus is blown from the nares.

**DIAGNOSIS**—The only absolute diagnostic sign of empyema of the antrum is the obtaining of pus from the cavity itself. For diagnostic purposes this can be done with a curved trocar used through the nose, or if the bone is sufficiently thin, by plunging a strong needle through the external wall immediately over the canine fossa. Of all the means at hand for diagnosis, the electric lamp or transilluminator (so-called) perhaps comes next. This will generally determine the presence of pus, but if the face is fat it will fail utterly, as it has in two cases recently in my own practice. In the average face, with a three-candle-power lamp in the mouth, the pink transillumination can be seen up to the orbit, occasionally the pupils of the eye being illuminated; if pus is present in the antrum the pupil cannot be discerned, and the antrum region is dark in comparison with the other side.

The persistent discharge of a bright yellow, cleanly-looking pus from one side of the nose should always excite suspicion of disease of one of the accessory sinuses. Such a discharge occurs only in the presence of a foreign body, in purulent rhinitis of children, syphilis or neoplasm, diphtheria, and sinus-disease. By exclusion we should be able to reach a correct diagnosis.

The periodic method of discharge will aid in diagnosis of antral disease. Upon examination the middle or lower turbinated bodies will usually be found coated with pus. Applying a cotton-wrapped probe to the lateral wall and making pressure, pus may be seen to ooze out from beneath the middle turbinated bone. Frankel makes the statement that this is a condition only found in antral disease. I have observed the same circumstance when the sinus involved was other than the maxillary.

In my own hands, peroxid of hydrogen has been one of the most satisfactory aids in diagnosis. Used in a hard rubber syringe with a long, small nozzle, the distal opening of which is closed and a small opening made in the side, the nozzle is carried along the nostril over the site of the normal opening and the stream directed laterally; when the stream comes opposite the opening, some usually finds entrance, and be the quantity ever so small, the gas formed drives out the pus immediately.

In the acute cases pain is complained of in the side of the face and forehead, but in the chronic cases, if present at all, it is referred to the supra-orbital, temporal and especially the occipital regions. This is to me a most peculiar circumstance, the cause of which I am at a loss to say.

Dr. Myles (*Journal Laryngology and Rhinology*, March, '95.) has observed the frequency with which occipital pain is complained of, and he gives no explanation for it. In certain cases percussion over the antrum may be of value, but the advantage to be derived is doubtful. When all ordinary means fail to establish a diagnosis and the symptoms still indicate pus in the antrum, a satisfactory and safe procedure is to pierce the internal wall of the cavity in the inferior meatus of the nose with a curved trocar and canula. Irrigation can be carried on through the canula.

**PROGNOSIS**—The prognosis is good if the patient is seen in the acute or early stage. Many cases recover without having been recognized. In the chronic cases the prognosis must be guarded and the patient must be made fully acquainted with the condition and requirements or he will soon drift into other hands. The disease rarely endangers the life of the patient unless the ethmoidal or sphenoidal cells are involved.

Cases which arise from intranasal diseases require persistent and long-continued treatment in connection with correction of the nasal obstruction or disease. Spontaneous resolution of chronic empyema of the antrum probably never occurs.

**PATHOLOGY**—The pathology has been referred to in discussing the etiology. It is well to remember that tumors are frequently met with in this region. Polypus, granulation-tissue, diseased bone, and bone-proliferation are the ordinary causes. In one case recently operated upon by myself, a malignant growth was found involving the greater part of the walls, which could not be removed. The presence of such was not suspected before the operation.

**TREATMENT**—In the treatment of suppurative antral affections free drainage is, first and last, the paramount requisite. If of the catarrhal variety, this, followed by frequent and thorough cleaning and disinfection will result in a cure. When nasal deformities, hypertrophies or polypi exist their removal is always indicated; in fact a certain number of cases will yield spontaneously when these conditions are corrected.

When the normal opening has become patulous, attempts may be made to introduce our cleaning and disinfecting solution by means of a canula; failing to reach the cavity by this means, nothing remains but to make a counter-opening. Either one of three methods may be used in operating, through the alveolar process, the canine fossa, or by the intranasal operation of Mickulicz. Sacrificing a sound tooth to gain entrance through the process is in my opinion to be condemned. If a decayed tooth is in place this should be removed and access may be had through the opening left. All that can be done through such an opening however, is probing and washing, on account of the distance through the bone. Such an opening is liable to result in permanent fistula. It is impossible to even thoroughly probe an antrum through such an opening, especially over the floor, where necrosis is usually found.

The intranasal operation is the easiest to make, as the bone at this point is extremely thin; the opening is made by simply plunging a Mickulicz knife (a triangular sharp-pointed blade at right angles to the staff) through the wall. Hemorrhage is slight and can be easily controlled.

In acute cases when an operation is necessary, this method is preferable, but in chronic cases where curetting and long-continued irrigation are necessary, it has the disadvantage of being inaccessible for purposes of

curetting and beyond the reach of the patient himself for irrigation. The alveolar operation I have found advisable only where there is a carious tooth in position. If curetting is necessary it will have to be followed by another operation. When it is anticipated that curetting is necessary, the operation had better be made in the canine fossa at once. This opening should be made large enough to allow of thorough exploration of all parts of the cavity with the ring curet. The lip is first dissected loose from the alveolar process, exposing the bone to a distance of from 1 inch to  $1\frac{1}{8}$  inches above the process. The opening in the bone we make with a hollow trephine using an electric motor for power. This drill cuts rapidly and smoothly, removes the disc intact and is by far the most to be preferred of all our drills. The drill employed being either a  $\frac{1}{4}$  inch or a  $\frac{3}{8}$  inch is started just above the canine fossa, about  $\frac{3}{4}$  inch from the alveolar ridge, in an inward and upward direction, the endeavor being to enter just above the floor. Hemorrhage is profuse for a few moments, but rarely gives any trouble. The cavity is now thoroughly explored for polypus or diseased bone, the same if present being removed with the sharp curet.

Meyrowitz of New York, makes a ring curet with a flexible shank which answers the purpose admirably. Following curetting the cavity is washed with peroxid of hydrogen and afterward from two or four quarts of bichlorid solution 1-1000 is washed through by means of a fountain syringe and catheter which latter fits the opening in the bone. The cavity is then packed with a strip of iodoform gauze, frequently requiring a strip a yard or more in length and of a finger's breadth. The washing and packing must be repeated every day and as the only method of repair is by cicatricial tissue, this may take considerable time. I have never met any indications or need of drainage tubes and believe they are unnecessary and a great annoyance.

*No. 11 N. Cleveland Avenue*

## Cleveland Medical Society

BY WM. E. WIRT, M. D., PH. D.

*Professor of Orthopedic Surgery in the Medical Department University of Wooster, Cleveland, Ohio; Orthopedic Surgeon to Cleveland General Hospital and Cleveland Hospital for Women and Children.*

ON the occurrence of these annual banquets we all feel that the occasion is furnished for declarations of good will and regard for others and of admiration for ourselves. We lay aside our studies of the mysteries of life, disease and death, and become, as it were, a society for mutual

*Address of retiring President*



admiration. And I may say that I firmly believe there has never been a time in the history of the medical profession of Cleveland when this could be done with as good grace as at the present moment. It will be my endeavor in the few moments allotted to me to prove the correctness of this assertion, by showing you what we have accomplished in the past, by calling your attention to the influences for good which this Society is exerting upon the profession at the present time, and by enumerating the forces which are acting to give us the possibilities of the future.

We are satisfied or dissatisfied in our management of affairs according as we have or have not accomplished in a satisfactory manner that which we set about to do.

In my inaugural address last year I presented to the Society a number of measures to be carried out during the coming year; these recommendations were all approved by the Society. We have had, as suggested at that time, the meeting devoted to Medical Abuses. This meeting called out a large attendance and brought about an enthusiastic debate, and it is our hope that good results will follow the free discussion we had on this subject.

We have successfully inaugurated a plan of complete stenographic reports of our meetings. This I consider the greatest advance made during the year and of the utmost importance to the Society, as it renders possible the publishing of our proceedings, requires accuracy on the part of the speaker, and greatly enlarges the usefulness of the Society. I recommended to the Society that a meeting be devoted to the subject of sewage. At the suggestion of our Secretary, Dr. Brokaw, this was enlarged in scope and was made a public meeting. This meeting was an eminent success in every sense, receiving great attention both in the medical journals and the public press throughout the country. Public interest was aroused in the subject, and it would appear that something definite will be done as a result of this agitation. A very important and interesting meeting which was planned at the beginning of the year was the one devoted to diphtheria and the anti-toxin treatment. This meeting was attended by and received the enthusiastic support of two hundred and twenty-five physicians.

We have published, as promised, the revised Constitution and By-laws of the Society, with a list of the officers and members, which publication has been sent to all the members. The non-resident membership has been increased, which is a measure I consider of the greatest importance in the development of the Society. As further evidence of work accomplished during the past year I will present to you some facts obtained from the minutes of the Society. Though they are dry abstract figures yet they are of interest to those who have been watching the growth of this organization and moreover it is the retiring President who is expected to furnish these figures. There have been read before the Society during the past year 28 set papers of which 17 were open for discussion. Each paper was discussed

on an average by six speakers. We have had six written reports of cases and nine informal reports of clinical experience. There were 17 clinical cases brought before the Society and 33 pathologic specimens exhibited and discussed, so that we have had as a total 93 exercises for the year. The number of pathologic specimens exhibited and discussed is about double that of last year, while the clinical cases brought before the Society are nearly trebled. This shows that the Society is developing in a clinical direction which is certainly a very desirable growth. The Society has three hundred members consisting of 6 honorary, 220 resident and 74 non-resident members. The average attendance during the past year for all meetings including the quarterlies, was 124, while for the regular meetings the average attendance was 92. By examining the records we see that the average attendance at the regular meetings is somewhat higher than in any previous year.

What influence, ladies and gentlemen, has the Cleveland Medical Society had on the medical profession of this city? To realize what this has been and what it is today, it is only necessary to call attention to the condition of medical affairs in Cleveland in the past and at the present time.

My first acquaintance with the medical profession of this city dates back eight years, though I have only been a resident of Cleveland five years. Yet in that short period of eight years—yes in the past five years—I have noted great differences. Five years ago it was difficult to collect together more than 25 or 30 physicians, and the largest assembly of Cleveland physicians that I saw prior to three years ago (the time of organization of this Society) was 32, while the average was about 15. At the present time we can get together on special occasions 300 or more, while the average attendance at our meetings for the past two years has been 130. Five years ago the medical men of this city were unacquainted with each other and were divided into numerous factions; while at the present time, though we do not always treat each other with brotherly consideration, yet it is generally conceded that the profession is now much more united than formerly, and I know that they are much better acquainted with each other than they were.

It is since the organization of this Society that the medical library has been developed. While the Cleveland Medical Society is willing to divide honors in regard to the organization of the Medical Library Association yet the members of our Society wish it distinctly understood that they were first to appoint a committee on the subject, and that they called upon the other societies to join them in the project; and further it was the unification of the medical profession brought about by the Cleveland Medical Society that made such a library association possible.

The Cleveland Medical Society has engaged actively in endeavoring to bring about suitable medical legislation, and while no such legislation has

recently been enacted, I feel reasonably sure that we are about to reap the rewards of our labor by the passage of the Mosgrove bill at the present session of the State legislature.

As a result of the organization of this Society great opportunity has been given young men to develop latent and unsuspected abilities in society work, and I have noticed that they have not been slow to grasp such opportunities.

This Society has made possible the hearing of lectures and the attending of clinics given by the most eminent physicians from our largest cities. These lectures have brought to Cleveland at various times large numbers of non-resident physicians. We thus become better acquainted with the practitioners of neighboring cities, friendly relations are fostered, we become more united in our common purposes, and thus is strengthened the power and influence of the medical profession of northern Ohio. Our Society has not only influenced the physicians of this city but it has made itself felt throughout the land, raising into prominence the city of Cleveland as a medical center. It is certainly gratifying for us to find that our Society is well-known both east and west. At the meeting of the Mississippi Valley Medical Association held at Hot Springs, Arkansas, something over a year ago, I found that our Society was well-known by those present and many were the questions asked me as to how it came that our Society developed so rapidly and by what method we kept up our high average attendance.

The Editors of the CLEVELAND JOURNAL OF MEDICINE inform me that they have recently received a San Francisco medical journal in which is copied from our former official journal nearly the entire proceedings of one of our November meetings. Some time ago, the Cincinnati *Lancet-Clinic* did the same thing.

The plan inaugurated by the Cleveland Medical Society of having distinguished medical men from other cities lecture before the Society has been copied by Detroit, Toledo, Cincinnati, Pittsburg and other cities. In regard to this very point, Dr. Foshay has just received the following letter from Pittsburg:—

“MY DEAR DR. FOSHAY:—

\* \* \* \* You are right in saying that your Society has stimulated the profession of other cities. Your example has been more than once quoted here. The plan of bringing distinguished men here from other cities to address the Academy has been a great success. Hobart A. Hare will be here on the evening of the 31st of January. \* \* \* \*

Yours very sincerely,

THEODORE DILLER.”

I have stated that this Society has brought into prominence Cleveland as a medical center. In confirmation of this I would say to you that which you will all be pleased, no doubt, to hear, that at the last meeting of the Ohio State Medical Society held at Columbus, an ex-president of that

association, Dr. Dandridge, who is a distinguished surgeon of Cincinnati, said to me in conversation, "Doctor, I have watched closely the progress of events in medical circles and I have come to the conclusion that Cleveland is destined to become the future medical center of Ohio."

Having called your attention in a very imperfect way to some of the attainments of the medical profession, stimulated as it is by the Cleveland Medical Society, let me briefly describe those conditions existing which give us the possibilities, medically speaking, of the future Greater Cleveland.

I would first remind you of the fact that we have, as a field to work in, a great and rapidly growing city—the ninth in extent of population in the United States and probably soon to be the eighth. This field is being rapidly enlarged by the electric lines radiating in all directions, with the result of greatly enlarging our suburbs. The direct effect of this on our Society will be to considerably increase our non-resident membership and in a like manner to increase attendance on their part.

While attendance is not all that is to be expected of our out-of-town physicians—for I feel confident that they will do their share of the scientific work—yet a mere matter of numbers is a great factor in stimulating good work on the part of the Society.

We have before us the prospect of a celebration this year of Cleveland's centennial anniversary. This will greatly advertise the city and increase its importance commercially and otherwise and I may remind you that there are few things that add to the greatness of Cleveland that do not also benefit the medical profession.

We have a medical library of but little over a year's growth that already has an endowment of over \$6000. This library is sure to grow and will ultimately become the pride of the medical profession.

We have four medical colleges, two of them of the regular school; of the two regular colleges one of them is endowed and the other has every assurance of being endowed within a short time. This insures for Cleveland a larger number of medical students than she has ever had before. We are blessed with two medical journals, one of ten years' standing and well-known throughout the country; the other, the official journal of this Society, which has just begun life, but gives every assurance of being a successful high-class journal. And last, but not least, we have this great Medical Society, which, I am sure, will do all in its power to make Cleveland a great medical center.

And now, Mr. Toastmaster, to give a brief recapitulation, I would say that with a great and rapidly growing city, with the enlargement of our suburbs by the electric lines, with a centennial taking place this year to advertise our city, with a rapidly growing medical library, with well-equipped and endowed medical colleges, with a medical society of three hundred active members, enthusiastic to the extent that they attend in larger num-

bers than in any city medical society in the United States, and with all these interests enthusiastically put forth by two medical journals, I think I am safe in predicting for the medical profession of Cleveland a great and glorious future.

## The Value of Aspiration in Empyema

BY WILLIAM CLARK, M. D.

*Visiting Physician to St. Alexis Hospital, Cleveland*

IT is generally conceded that aspiration alone is not usually successful in curing empyema. It is true cases are reported that were cured by aspiration, but such are exceptions to the rule. Therefore, we look to resection of the ribs, with proper drainage, combined with the administration of cod-liver oil, iron, etc., to cure the majority of our cases of such trouble. But while aspiration will not usually cure empyema, it seems to me in a great many cases a powerful aid to a cure. Especially is it so in those cases in which the lung, forced to the apex of the pleural cavity by a large effusion, is bound firmly there by adhesions. In such cases, while the operation is a success, in that the pus is liberated and the patient is shielded from the dangers of septicemia, yet when we follow out such cases for some time we see that most of them have a doleful end. There is a continuous discharge of pus from a cavity in many cases too large to be filled by granulations and which cannot collapse on account of the rigidity of the ribs. When this condition exists for some time the chronic inflammatory trouble so changes the pleura that it becomes hardened and thickened so as to have the resistance almost of bone itself. In one case which I saw the pleura was  $\frac{3}{8}$  of an inch thick and so hard and tough and rigid that it had to be cut through with a bone-forceps. When we have this condition of things, even a multiple resection of ribs—to allow the side to collapse and heal by granulation—will not suffice, and the whole of the tough, rigid pleura must be dissected out, entailing a great amount of shock. When in such cases this operation is not performed, there is but one end for the patient. The constant discharge of pus robs him of large amounts of phosphorus and phosphoric acid, and in the end brings on lardaceous degeneration of the spleen, liver and kidneys, and the patient dies from exhaustion or uremia.

How is such a state of affairs to be avoided? By early and continued aspiration. Of course in cases where the patient is having a septic absorption from the pleural cavity with chills, fever and sweats, we cannot wait to try aspiration, but must resect and wash out the cavity at once. But in those cases in which such condition does not exist, early and continued aspiration should be practiced. What does this do? The withdrawal of the pus produces a vacuum in the pleural cavity and the atmospheric pressure of 15 pounds to the square inch plus the weight of the lung, has a constant ten-

dency to make the lung expand and fill up the space. This loosens the adhesions between the visceral and parietal layers of the pleura and allows the lung to come down. In this manner we can get the lung to almost fill up the cavity, when new adhesions will form and hold it there. When the lung is in this condition the ribs should be resected; for you have far less of a cavity to be filled up by granulation and the adhesions between the two layers of the pleura fill up the space and hold the lung in position. By so doing you not only shorten the time of convalescence after operating, but you give a greater chance of recovery to those cases who otherwise become a walking advertisement of your lack of success, and have only a small chance of escaping amyloid degeneration and its consequences.

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### Hypertrophy of the Lingual Tonsil with Report of a Case

BY HOWARD S. STRAIGHT, M. D.

IN June, '95, a woman, aged 38 years, a professional soprano singer, consulted me as to a slight hoarseness of long standing. She also complained of a feeling of fulness in the throat, a tendency to frequent swallowing and a sensation at times of a foreign body in the throat. She had a deviation of the septum removed, and a cauterization of the lower turbinated bodies, as well as local laryngeal treatment. This treatment had not relieved the patient.

An examination of her upper air-passages revealed a marked enlargement of the lingual tonsil. No other abnormal condition was present. Her general health was perfect. After anesthetizing the parts with a 20% solution of cocain, the greater portion of the hypertrophied mass was removed with a Myles gylotome. Some of the masses removed were one-third as large as the tip of the index finger. As soon as the hemorrhage ceased the patient tried to sing and said she could control her voice better than before the operation and that it seemed clearer. I succeeded in removing enough of the mass of hypertrophied glands at the first sitting to relieve the patient's symptoms entirely. Nothing more was done locally. I gave her a nerve-tonic on general principles, because the possible nervous element in such a case ought always to receive due consideration. This tonic was continued for a month. She was kept under observation for three months. The hoarseness passed away within ten days and did not return. The feeling of fullness and the tendency to frequent swallowing also promptly disappeared. The result was as stated up to October 1st, at which time she went abroad to continue her musical studies.

A large number of lymphatic follicles exist normally at the base of the tongue between the epiglottis and the circumvallate *papillæ*. Under normal conditions, these glands do not project above the surface of the tongue. This aggregation of glands forms the lingual tonsil and the base of the so-called

"lymphoid ring"—the pharyngeal tonsil, the faucial tonsil and the lingual tonsil.

When hypertrophied, the glands project above the surface of the base of the tongue and press upon the epiglottis, more or less according to the amount of hypertrophy. Normally the surfaces of the epiglottis and tongue do not touch. If the enlargement is marked, the epiglottis may be nearly buried in the masses, or may lie in constant apposition. Even when not markedly enlarged, their presence causes an excess of secretion and an irritation in the throat, as well as the symptoms in the case cited. One can easily see how a throat-cough can be added to the list of symptoms. The disease occurs most frequently in adult women from 20 to 40 years of age. Cases are occasionally seen in women younger and older than those ages and in men. It often occurs in the patients who have had enlarged tonsils or adenoid growths earlier in life. Many of the cases have also a hypertrophic rhinitis or unatrophied adenoid growths. In such cases it is impossible to decide which factor may give rise to the symptoms. The only rational procedure is to rectify all the morbid conditions. In the case reported, it is a fair inference that the lingual tonsil caused the trouble. Her history pointed to a slight deviation of the septum and no very marked nasal disease. The symptoms in hypertrophy of the lingual tonsil depend very greatly upon the susceptibility of the patient as well as upon the amount of enlargement.

Moderate enlargement may give rise to no symptoms whatever. Patients in whom such hypertrophy occurs are often in depressed health and have either gastric, uterine or pulmonary disease.

An enlargement so slight as to occasion no discomfort whatever when the patient is in normal health, may, when the health is depressed, rapidly increase in size and occasion marked disturbance. In such a case, constitutional treatment becomes all-important, and it is a question whether local treatment is necessary. If the local symptoms are severe, removal of a portion of the mass will more rapidly relieve the suffering of the patient than the slower methods of constitutional treatment. While the patient may recover, as far as the general health is concerned, it does not follow that the hypertrophy of the lingual tonsil will also disappear. Removal of a small portion of the mass is such a simple matter that one need not hesitate to operate even to relieve the patient temporarily. No more is known as to the etiology of enlargement of the lingual tonsil than the enlargements of the faucial and pharyngeal tonsils. For marked hypertrophies various measures are recommended, *i e.*, applications of chromic acid, reduction by means of the galvanocautery, snare or gylotome. My preference is for the gylotome in ordinary cases. The hemorrhage, after removal by means of the gylotome, is usually insignificant. It is not always possible to remove all the tissue desired at the first sitting. The throat rapidly fills with blood and what cannot be done quickly must be left until a later date. The throat is, as a rule, very sore for twenty-four hours, but within three or four days all tenderness from the operation passes away.

Care must be exercised not to remove too much tissue, lest the resulting contraction interfere with the movement of the epiglottis. The results of removal of hypertrophy of the lingual tonsil are as a rule, very satisfactory, and the pain caused by the operation is insignificant.

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# Cleveland Journal of Medicine

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## EDITORIAL

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### How to Know the Typhoid-Bacillus

OF considerable interest seems to be the method recently discovered by Elsner for differentiating the bacilli of typhoid-fever. Bacteria which occur in feces are especially hard to isolate; germs swarm in the intestinal canal in such countless numbers and great variety as to put it out of the question to distinguish them even by the microscope, without differentiating stains. Elsner's method consists in making cultures on potato-gelatin impregnated with one percent of potassium iodid. He finds that few bacteria live at all on this medium. Besides a few liquifying saprophytes,



the typhoid and colon bacteria are the only ones which survive. The resulting colonies may be easily recognized, those of the colon bacterium well-grown at the end of 24 hours, fairly large, brown, coarsely granular spots. Those of the typhoid-bacillus transparent, much like a drop of water, small, finely granular, and only well-developed at the end of 48 hours. Of 17 cases of typhoid tested by Elsner, he obtained from 15 cases numberless cultures without a failure; of the other two, one was examined during the seventh week, the other one two days before defervescence. Of 5 cases of well-marked typhoid in which the method was tried by Lazarus, reported in the *Berliner Klinische Wochenschrift* of December 9th, 1895, he failed in no case to obtain quite characteristic colonies of the typhoid-bacillus.

The method is suggestive as well as useful. The only logical way to classify germ diseases is by the germ which causes them. A diarrhea caused by the typhoid-bacillus may be less severe than some caused by the colon bacterium, and diphtheria may be milder than follicular tonsillitis. General tuberculosis may give rise in its early stages to milder symptoms than malaria. It is the species of the germ which determines very largely the prognosis and treatment of the one case, and still more the prevention of others. Until technic is so perfected that the obscure and atypical cases can be recognized, the origin and spread of epidemics may be expected to be occasionally shrouded in mystery. A symptom-complex does not make a disease. A patient with diarrhea, fever and enlarged spleen may be innocent of typhoid, and one with no fever and no diarrhea may possibly cause an epidemic.

Apart from its diagnostic worth such a method is valuable as adding to our general stock of knowledge of the life-habits of bacteria. Physicians are daily becoming scarcer who decry the whole germ-theory; there are signs, however, of a reaction-wave against most of the single discoveries on which it is founded. It is certain *a priori* that such discoveries as Pasteur's inoculation for rabies, Laveran's discovery of the plasmodium, and the various antitoxin treatments will be assailed. It should be borne in mind that genuine discovery is hard, and the originality of dissent is easy. The burden of proof may be fairly said to rest, in the case of a generally accepted theory, on the disbelievers.

## Cleveland Water

IT requires no unusual powers of perception to discover that the mechanical purity of the water supplied to the citizens of this city is at present at an alarmingly low ebb. As to the biologic and chemic purity, or impurity, we have no knowledge, except the clinical evidence that diarrheal diseases are widely prevalent, as indeed they usually are at this season of the year, when the cold checks oxidation of the city's filth, and high winds carry the sewage right to the intake-crib. When the lake freezes the wind no longer enters into the problem, it is true, but oxidation is then practically *nil* and the sewage-laden river water spreads out widely off the city's shores and is delivered to our homes in its pure (?) state.

As to remedies it may be pertinently remarked that extending the tunnel five miles into the lake is a temporary makeshift and can at best but postpone for a longer or shorter time, depending upon the future rapidity of growth of the city, the ultimate wrestling with the problem of pure water. No remedy, absolutely, will meet the indications except the one of keeping the filth out of the lake.

The method by which this may be accomplished can best be determined by a commission of expert engineers, such as is now in the service of the city, after a careful survey of the necessities of local conditions.

A system of intercepting sewers is, of course, a necessary part of any efficient scheme, but, instead of the generally accepted proposition of carrying the sewage a few miles east along the lake shore and then turning it into the lake, either in its pristine state or after purification by any one of several methods, we would repeat a former suggestion of what seems a feasible and preferable alternative: This is to carry the city's sewage up the river to that part of the flats which is not desirable for building purposes and never likely to become so, and there purify it by some method, preferably that of intermittent filtration, and to discharge the pure effluent from the filter-beds into the river where it would serve well for flushing purposes.

### Necropsy

IN the interests of euphony and accuracy of statement it seems desirable to direct attention to the words used by medical men to denote the pathologic examination after death.

The *Medical News* not long since admirably discussed these terms. The most frequently used term is at present undoubtedly *post mortem*, as all know two Latin words meaning "after death." This term is awkward and difficult to anglicise and has nothing to recommend it.

The next most frequently used term is "autopsy," derived from two Greek words meaning literally "to cut one's self;" the secondary meaning is, of course, "to cut for one's self," *i. e.*, so as to see for one's self the morbid anatomy.

In our opinion the preferable term, both by reason of its etymology, of its euphony, and of its clearness of meaning, is the word "necropsy." This means of course "to cut a dead body," and is, hence, accurate in significance. It is rapidly coming into general use among the best medical writers and speakers, and we would urge our readers to use this term in the future, both because its use is bound to spread and because of the good reasons stated above.

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### Removal of the "Medical News"

AMONG a number of changes which are noticed in the realm of medical journalism since the first of the new year none is more startling than the removal of our esteemed and staid contemporary, the *Medical News*, from Philadelphia to New York. The *News* has been published in Philadelphia since 1843, and has come to be regarded by the profession as one of the well-established medical institutions of that city. A number of other Philadelphia journals have in times past made the same move, some have remained in New York and others, after a shorter or longer trial, have returned to the city of their first (brotherly) love.

An additional feature of the removal of the *News* is the retirement of Dr. Geo. M. Gould from the editorship and the assumption by Dr. J. Riddle Goffe, of New York, of that position.

Dr. Gould has been eminently successful in the world of journalism and we regret sincerely his retirement from it.

We welcome Dr. Goffe, of whom we hear many complimentary expressions, and wish the *News* all possible success under the new circumstances.

### Professor Morley

ALTHOUGH a little apart from strictly medical lines it is a pleasure to note the appearance of the Smithsonian Institution Monograph, *On the Densities of Oxygen and Hydrogen and on the Ratio of their Atomic Weights*, by Professor Edward W. Morley, Ph. D., our renowned fellow-townsmen. This little work of 117 pages recounts the results of ten years patient and unremitting toil by one of the greatest and most thorough of America's scientific men. The reception of this work by the scientific public cannot better be conveyed than by quoting the closing paragraph of a review of the book by W. A. Noyes in the current number of *Science*: "It is impossible in a brief sketch of this kind to convey any adequate idea of the pains which was taken at every step to secure the greatest possible accuracy in the work, nor of the genius which has been displayed in devising complicated apparatus adapted for the determinations to be made. The work is classical and must, hereafter, be consulted by everyone who wishes to do the best work in this field."

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### "Medicine"

THE appearance of the first number of the second volume of *Medicine*, the monthly medical journal edited by Harold N. Mayer, M. D., of Chicago, and published by George S. Davis of Detroit, prompts the just comment that no medical journal that we have seen at all approaches it in newness and beauty of typography or, in general, in the quality of the printer's and publisher's work. In contrast with the host of so-called medical journals, printed poorly upon inferior paper, it is a keen pleasure to pick up a number of *Medicine* and realize what an important part the mere mechanical work put upon a journal plays.

It must not be concluded, however, that charm of appearance is the only good quality of *Medicine*. It is well edited and its pages are clean and free from any objectionable feature. It deserves a place among the very foremost of American medical journals and we sincerely wish it a full measure of success. The general quality of medical journals of this country is so low that the success of all the better ones is to be devoutly wished for by all physicians who feel a pride in American medicine.

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THE *Journal of Experimental Medicine*, a periodical to appear at least quarterly, will be published at the beginning of the year by D. Appleton & Co. The journal, which is to be devoted to original investigations in physiology, pathology, bacteriology, pharmacology, physiological

chemistry, hygiene and medicine, will be edited by Professor William H. Welch, of Johns Hopkins University, with a board of twelve associate editors, as follows: For physiology, H. P. Bowditch, Harvard University; R. H. Chittenden, Yale University; W. H. Howell, Johns Hopkins University. For pathology, J. George Adami, McGill University; W. T. Councilman, Harvard University; T. Mitchell Prudden, Columbia College. For pharmacology, John J. Abel, Johns Hopkins University; Arthur R. Cushny, University of Michigan; H. C. Wood, University of Pennsylvania. For medicine, R. H. Fitz, Harvard University; William Osler, Johns Hopkins University; William Pepper, University of Pennsylvania.—*Science*.

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### The State Medical Society.

IT is not too soon to commence talking of the approaching meeting of the State Society. It is much to be hoped that this year will see Cleveland occupy that position in the Society which its growing prominence as a medical center warrants. Southern Ohio has had most of the good things for some years past, and the time is now at hand for a change. All that is necessary is for the doctors of the northern part of the State to make up their minds to attend in full force. It ought to be easy for this city to be represented by 60 to 75 physicians.

A movement is also on foot to ask the Society to meet here in 1897. This is a good move. With a northern Ohio man for President, and with the powerful assistance which our own Society can give, there will be no difficulty in making it a banner meeting, or in demonstrating by our hearty and unanimous hospitality that Cleveland's medical profession is not behind the times.

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### Medical Education

NO better index of the constantly advancing standard of medical education can be cited than the following rule, recently adopted by the Medical Department of the University of Pennsylvania, which provides that no graduate of a three-year school may enter the fourth-year class of this institution except by passing an examination in all the branches which have been completed by the University student in his first three years. These branches are as follows: general and medical chemistry, materia medica and pharmacy, elements of general pathology, the entire subjects of anatomy and physiology, applied anatomy, general and special pathologic anatomy, therapeutics, surgery, obstetrics and gynecology.

## A High Standard

THE Medical School of Harvard University has just made a rule which will be a powerful aid to the cause of higher medical education:

"On and after June, 1901, candidates for admission to the medical school must present a degree in arts, literature, philosophy, science or medicine from a recognized college or scientific school, with the exception of such persons of suitable age and attainments, as may be admitted by a special vote of the Faculty taken in such case. All candidates, whether presenting a degree or not, are and will be required to satisfy the Faculty that they have had a course in theoretical and descriptive (inorganic) chemistry and qualitative analysis, sufficient to fit them to pursue the courses in chemistry given at the Medical School."

The latter provision is commendable. A medical school is no place to teach general chemistry.

## Legislation

DR. J. A. KIMMEL, of Findlay, who is a member of the present Legislature, has been appointed Chairman of the Standing Committee on Medical Colleges, Medical Societies, etc., by the Speaker of the House of Representatives. Drs. Hensly, Conn, Reed and Jacobs are also members of the Committee. The outlook for medical legislation is thus better than ever before, certainly as far as the committee-stage goes. We are also reliably informed that the homeopaths all over the State are well organized and propose to work strongly for the Mosgrove Bill. So soon as the Bill is reported to the Assembly every physician in the State should address a personal letter to the representatives from his county urging the prompt passage of the Bill. It would also be well for us all to ask our influential lay friends to do us the small favor of writing at least one similar letter. There is no such word as "failure" on the medical horizon this winter.

## A Loss to Medical Journalism

THE retirement of Dr. George M. Gould from the editorship of the *Medical News* is a great loss to medical journalism in America. His sound judgment, impartial criticism, honesty of purpose and scholarly attainments have won for him a reputation which has been well earned and is well deserved. In company with his host of friends, we tender to him our best wishes for his future success.—*Medical Record*.

## The Journal's Advertisers

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Those of our readers who feel that the efforts of the JOURNAL in behalf of the medical profession are worthy of encouragement can be of great assistance to it by corresponding with the firms who advertise in its pages, and by using the products they advertise whenever they can do so conscientiously.

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## Good Fortune for a Cleveland Medical School

**A** COUPLE of weeks ago it was our pleasure to have some conversation with Dr. C. E. Slocum, of Defiance, O., who is one of the Trustees of Delaware University, in which he spoke in glowing terms of the hopeful prospects of that institution in its new relations with one of the established medical schools of Cleveland. The doctor feels so good over the matter that he has had transferred from his bank account to that of the University the goodly sum of fifty thousand dollars. Dr. Slocum is not as rich in this world's goods as Mr. Rockefeller, or some other American citizens, but his heart and soul are just as large and he is just as generous. —*Lancet-Clinic*, Jan. 4, '96.

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## The Journal

**T**HE CLEVELAND JOURNAL OF MEDICINE proposes to represent to an extended degree the profession especially of northern Ohio and to a less extent the rest of the State and surrounding territory. The JOURNAL will also at intervals publish original articles by some of the well-known teachers of the East, which will be prepared exclusively for the JOURNAL. Our main interest, however, is always to knit together Cleveland and northern Ohio in an active endeavor to raise the standard of medical culture in this region, and to foster the interests of Cleveland as a medical center. Future announcements in the JOURNAL and its succeeding numbers will make clear the catholicity of its ideals.

OFFICIAL PROCEEDINGS  
OF THE  
Cleveland Medical Society

REGULAR MEETING DECEMBER 27, 1895

*The President, DR. WIRT, in the Chair*

The minutes of the last meeting were read and approved.

**Report of Committees**

THE PRESIDENT announced that the Health Officer requests the Committee appointed by the Chair a couple of months ago to confer with him in regard to drawing up a bill on local medical legislation, to meet at the Health Office tomorrow afternoon for the purpose of discussing the proposed ordinance. Dr. Tuckerman, Dr. George Upson and Dr. O. B. Campbell, constitute the Committee.

**New Business**

The Secretary read an amendment by DR. H. S. STRAIGHT to Article VI of the By-Laws of the Society. Amendment intended to be Section 10. It reads: "No member shall consume more than five minutes in the report of a case or exhibition of a specimen, without the consent of the Society."

DR. H. T. CLAPP moved that it be changed, and the words "without the consent of the Society," be struck out, and the matter left with the President.

**Report of Cases and Exhibition of Specimens**

DR. M. ROSENWASSER: I have here a specimen which I wish to show. I will be very brief in order not to cut off other more agreeable entertainment tonight.

This is a specimen from a woman 37 years old, married at 14 years of age. She had had miscarriages and had suffered a good deal from hemorrhages, until about three years ago, when she discovered that she had a tumor—discovered it by going to her physician to find why she had trouble with her urine. The woman was operated on, but the surgeon who operated found that there were so many adhesions about the tumor and about one of the appendages that he simply removed the right appendage and the patient recovered, of course with the tumor. He assured her that he did not suppose she would ever become pregnant because the other appendage was so closed by adhesions. But she did become pregnant. She menstruated in August last and came to me about two weeks ago, and I found that she was then about four months pregnant. Fetal heart sounds could not be heard. She had a fibroid in the lower segment of the uterus. Efforts had already been made to produce an abortion, unsuccessfully; and I felt that even if an abortion were instituted there were great dangers from sepsis or hem-



orrhage, possibly as great as if we removed the entire uterus at the same time. I advised her to wait a little while but she insisted on the operation and did not care to wait.

I operated on her last Monday and removed this uterus which is presented to you. In the lower segment you will find the tumor. In the upper portion you will find the placenta attached to the left side of the womb; that is the side on which the appendage had not been removed. You will find the fetus is here present also. If you will turn it the other side up you will find the appendage removed with it. After having removed the tumor I then separated the adhesions and sewed up lacerations on the peritoneal surface. The patient is practically out of danger today. The pulse is 90 and the temperature 99°; there are no outward symptoms.

DR. CRILE: I have a case here of total laryngectomy that I shall not have another opportunity of showing. I will take but a minute. The disease was carcinoma of the larynx. Total laryngectomy was made on the second of this month. Three of the upper rings of the trachea were removed as well as the larynx and epiglottis. In spite of this operation he is here tonight and was able to accept an invitation to go out of the hospital to dinner on Christmas day. He does not wear any tube whatever.

THE PRESIDENT: Of how long standing is the disease?

DR. CRILE: I would refer to Dr. H. G. Sherman for that part of it.

DR. SHERMAN: I really feel as if I were not prepared at this time to discuss a case of so much interest. The first time I saw this case there was without question a simple papillomatous growth. The case was referred to me by Dr. H. M. Page of Hiram. The growth at that time was circumscribed, and could be made out in its entirety; inasmuch as it had existed for a year and a half I had no hesitancy in pronouncing it a papilloma. The case passed out of my hands and was operated on by one of my brother specialists who spent eight hours continuously with the curet endeavoring to remove the growth. I saw the patient six weeks after this operation and at that time I changed my mind in regard to the nature of the tumor. The entire half of the larynx was indurated and excoriated. The growth had taken on a different character, and I felt that its nature had also changed, as papillomatous growths do undergo a very rapid change from benign to malignant when disturbed. I said to the man that I would not undertake operation until I determined the nature of the growth. Drs. Ohlmacher and Howard pronounced it carcinoma. I had the pleasure of referring the case to Dr. Crile.

DR. CRILE: There is one very strange thing, that after the larynx is totally removed the patient is able to talk. He talks with the nurse and with me. It is done by buccal voice. The mechanism of this is not very well understood.

## Program

DR. F. S. CLARK read a paper on "Pelvimetry: Its Importance in Obstetrics."

DR. N. S. SCOTT: As the program is so long, and since this is a most valuable paper and cannot be discussed as it ought to be, I move that the discussion be postponed to the second meeting in January. Carried.

DR. GEORGE HENRY FOX, of New York City, under the heading of "The Diagnostic Features of Cutaneous Syphilis," exhibited a large number of stereopticon pictures showing the characteristic appearance of the lesions, as well of syphilis as of eczema and other diseases with which it may be confused. In introduction, Dr. Fox said:

MR. PRESIDENT, LADIES AND GENTLEMEN: Permit me at the outset to thank you for the kind invitation which has been extended to me to appear before you this evening and to say to you that it has given me great pleasure to accept it, and that I fully appreciate the honor thus conferred upon me.

I have no paper to read, but simply appear tonight in the role of a showman; but I trust that the lantern slides on cutaneous syphilis, to which I shall call your attention, will speak more eloquently and more instructively than any paper I could possibly write and present.

Syphilis is a disease with which every practising physician ought certainly to be acquainted, for whatever the character of one's practice, this disease, in some one of its protean forms, is certain to crop out; and the successful treatment of the cases will depend entirely upon the recognition of the disease. The treatment, as you know, is usually a simple matter, but the diagnosis is not always so easy. The dermatologist has one great advantage in the recognition of cutaneous syphilis. Whereas the ophthalmologist teaches that there are cases of syphilitic iritis which present no peculiarities from iritis of non-syphilitic origin; while the neurologist may be unable to recognize the syphilitic origin of locomotor ataxia; the student of cutaneous syphilis can acquire the faculty, with a certain degree of success, which will enable him to recognize the syphilitic origin of the eruptions without asking the patient a single question. In fact, every patient with cutaneous syphilis has the diagnosis of his disease written upon the skin, and written usually in characters so plain that he who runs may read, provided only that he has made himself master of the pathologic alphabet which is the key to the diagnosis.

Now expertness in diagnosis depends entirely upon the cultivation of our powers of observation. You cannot learn the diagnosis of syphilis from text-books. You cannot learn it from lectures. It is only by seeing case after case and noting the salient characteristics of the disease that one is enabled to recognize it whenever he is brought before it. We recognize various trees that we see even at a distance, and you say one is an elm, another an oak or an ash, though perhaps half a mile away. You have not learned this from Gray's Botany. You have learned it simply from observation. You recognize on the street that a man is an Irishman, or a German, or a Scotchman, and I don't believe you could tell how you know it, but you have acquired the power from observation.

And so the manifestations of syphilis upon the skin become easy to recognize the more familiar with them one becomes and the more cases one sees; and tonight I hope that the large number of slides which I have will show you the salient points, and that the characteristic clinical features of these eruptions will be presented to you in a very striking manner.

Dr. Fox accompanied the exhibition of his slides with explanatory remarks.

## Discussion

DR. G. A. ORWIG: I would like to ask the Professor if there are lesions of the skin which are characteristic of congenital syphilis?

DR. M. BORTS: I would like to ask if it is possible to make a diagnosis simply from the scars.

DR. R. M. WOODWARD: I think we have all enjoyed this exhibition of Dr. Fox's, and I would like to ask him a question or two from a practical standpoint. One is; when the patient is suspected of having syphilis and there is no skin eruption, upon what symptoms or signs does the doctor base his diagnosis of syphilis? This is a disease of which I have a good many cases at the Marine Hospital, and I have learned to cast aside in some measure the enlargement of the postcervical gland, and in lieu of that I have taken up the epitrochlear. In a large number of cases we will find enlargement, where in some cases there is no enlargement of the glands of the neck whatever.

Another thing I would like to ask the Doctor is his opinion of the ultimate curability and eradication of constitutional syphilis.

DR. L. B. TUCKERMAN: I would like to ask the Doctor for his opinion of the hypodermic use of mercury in the treatment of syphilis.

DR. J. B. MCGEE: I would like to ask the Doctor his opinion as to the value of the mixed treatment of syphilis.

DR. D. S. HANSON: I would like to ask how universal he finds tenderness of the sternum?

DR. FOX: So many questions have been asked that I must speak very briefly upon those I answer.

In regard to the first question, the characteristics of congenital syphilis, these are some commonly mentioned; peculiar shape of the head or face, flattening of the nose, and almond-shape of the eyes. The weazen look of infants, upon which stress is often laid, does not of necessity indicate that the little patient is suffering from hereditary syphilis. There are others who can, perhaps, recognize syphilis from these characteristics. I must say that personally I am unable to do so.

As to the scars, you cannot tell that a patient has syphilis from certain scars, on account of their appearance, because there is no such thing as a characteristic syphilitic scar. But, as I have said, if you find scars about the knee, they are probably syphilitic. If you find a small, round, depressed scar, which is generally described as characteristic of syphilis, it is probably of syphilitic origin, although it might occur from a drop of acid. It would not be apt to occur from a boil or carbuncle. That small, depressed scar is generally syphilitic, but not of necessity. But if those small scars, in themselves not characteristic, happen to be arranged in a semicircular form, no accident caused them, but syphilis. It is that arrangement which is characteristic.

In regard to the signs of syphilis, early syphilis, I suppose is meant, when there is no eruption on the skin or soreness of the throat, or stiffness of the joints, it is true that the cervical glands are often not perceptibly enlarged. The epitrochlear glands had better be examined, but in no case have I regarded the induration of the glands as forming a basis for diagnosis of syphilis, because they are so often apparently normal. When you find a row of glands all along the arm or upon the neck, combined with other

symptoms of syphilis, you may say it is characteristic of syphilis. But in a large number of cases I have gained no help whatever from the condition of the glands.

As to the curability of syphilis—I believe that syphilis is curable. I believe it tends to run its course just as does scarlatina or measles. All diseases may have *sequelæ* which are not desirable, but syphilis in a man of good constitution, not dissipated, who takes proper care of himself, tends to run its course. I will not say it runs it in two years or three or four and a half. But syphilis can be cured, I believe, in the majority of cases, under proper treatment, and even without any mercury or iodid of potassium, I find that syphilis can be cured. I know of many men who have had syphilis to my knowledge fifteen years or more who are married now and have healthy children; and to say that such men are syphilitic is utter folly. I will admit that a great many cases of syphilis are not cured, and many years after the patients suffer from brain diseases and various other diseases which may or may not be attributable to syphilis. I think it is a great mistake to attribute every trouble in a syphilitic subject to syphilis.

In regard to mixed treatment, while I believe theoretically that it is better to use one drug at a time and know exactly what result you are obtaining and endeavor to learn something about it, I am in the habit, as many of us are, of indulging in a shotgun prescription. But I believe it is better to use the two remedies separately. I will not say that I do not believe there is any advantage in the combination, but I have never been able myself to see any advantage in the combination of these two drugs which cannot be obtained from either used separately.

As to the use of hypodermatic injections in the treatment of syphilis, and also inunction, I have used them and never expect to use them again. I have no trouble whatever in treating patients satisfactorily to myself and satisfactorily to many of the patients by the simple old plan, with which you are so familiar that you have perhaps lost respect for it—the treatment with protiodid of mercury given by the mouth. I believe that will produce the best effects, in combination with general tonic treatment, that can be produced. There are some men who always want something new, even if it is no better than the old.

I regard inunction as so undesirable a method of treatment that I do not care to use it any longer; and when it comes to daily or semi-weekly injections into the skin I have never seen enough benefit result from it to lead me to give up the old familiar method which is so very satisfactory if it is used in connection with the ordinary treatment of the patient regardless of his syphilis. If I may be permitted, I would lay stress on that point. If I have learned anything in the last twenty years I have learned this, it may sound heretical to some of you, that many patients, nine-tenths, perhaps, of the patients who come to New York doctors (and I presume it is so here) *do not need medicine*. If a man has been eating mince-pie three times a day he does not need a prescription to overcome his dyspepsia. If he has been overworking or sitting in his office all day long and not getting enough exercise and does not feel well, has been smoking or drinking too much, all he needs is to change his habits of life.

There are some drugs that will do a great deal of good, but they are to be used as adjuvants and should not be resorted to the first thing. I believe many cases of chronic skin disease other than syphilis will get well if

they will go to some trainer and follow his advice (if they don't follow his advice he will probably use profane language.) If they go to a doctor, he writes his Latin prescription, and says, "don't smoke too much," and gives a lot of good advice, but the patient goes off and takes the medicine and does as he has been doing.

Now, having seen the fact that almost every man, woman and child will improve under the care of a trainer (assuming that he has no valvular disease of the heart) I have come to the conclusion that arsenic, though a valuable remedy in some skin diseases, is hardly worth the paper on which the prescription is written. I have made up my mind that a little general treatment (you all believe in fresh air, diet, etc.,) is the best. But do we insist upon it when we treat the patients? We may give them good advice but just as certainly as we write that inevitable Latin prescription the patient forgets the advice but gets the medicine and takes it religiously.

In the treatment of all chronic skin diseases if you will adopt the plan of the trainer you will have no occasion whatever to write the prescription. The patient will get well. This is the one thing which I believe the profession has got to learn. Do not think that I believe the less in medicine. It is because I believe more strongly in the benefit that can be obtained from general treatment of the patient that I make these disparaging remarks in regard to the ordinary treatment which so many of us are apt to pursue.

DR. WOODWARD: I think the Society is under obligations to Dr. Fox for his delightful entertainment, and I move that we extend to him a vote of thanks. Carried.

THE PRESIDENT: A vote of thanks is extended to Dr. Fox.

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### The Cleveland Medical Society

REGULAR MEETING JANUARY 10, 1896

FOLLOWED BY

### The Third Annual Banquet

AT THE HOLLENDEN

*The President, Dr. Wirt, in the Chair*

The minutes of the last meeting were read and approved.

#### NOMINATIONS FOR MEMBERSHIP

DR. L. K. BECK, 190 Euclid Avenue, graduate of Western Reserve University, 1890; presented by DR. H. S. STRAIGHT.

DR. CARL TUTTLE, Berlin Heights, O., graduate of the Medical Department of Western Reserve University, 1894; presented by DR. H. S. STRAIGHT.

The report of the Treasurer was received.

THE PRESIDENT: Between now and the next meeting the incoming President will call a meeting of the Council at which time this report of the Treasurer will be examined by the Auditing Committee.

## ELECTION OF OFFICERS

DR. UPSON: I move that the rules be suspended and that those members nominated one month ago be unanimously elected as the officers for the coming year. Carried.

The Society then adjourned to the Hollenden Hotel where the annual banquet was served. The banquet was in every way a success. The attendance was large; the presence of the ladies directly or indirectly introduced in the Society was an enjoyable feature.

The Toastmaster, Dr. H. G. SHERMAN, introduced the speakers in a felicitous manner. The following toasts were responded to: Address of retiring President, Dr. Wm. E. Wirt; address of incoming President, Dr. J. E. Cook; address, W. F. Carr, President Bar Association; Our Aims and Realizations, Dr. M. Rosenwasser; Our Non-resident Members, Dr. N. S. Everhard; Response, Wilson M. Day, President Chamber of Commerce; The Personality of the Doctor, Dr. H. H. Powell; the Ladies, Dr. R. M. Woodward; selections, Mrs. Dr. T. M. Sabin; address, Mayor McKisson; response, Rev. Marion Murdoch.

It will be impossible to do justice to the responses to the different toasts, which were in every way enjoyable. The following, from the response by the President of the Chamber of Commerce, and from that of the sponsor of the Country Doctor, are given as in every sense representative.

MR. WILSON M. DAY said in part:

Mr. Toastmaster, Ladies and Gentleman, the Toastmaster of the evening has been so accustomed to looking down men's throats that looking down mine he thought he discovered a speech, but I assure him the thing he saw in my throat was not a speech but my heart.

It gives me pleasure to say to you that the Cleveland Medical Society and the Cleveland Chamber of Commerce have many things in common. We have to do with the body politic; you have to do with the physical body. You study symptoms and seek remedies. We study our city; we try to see wherein the source or seat of disease lies and we seek a practical remedy. You sometimes have to deal with a disordered liver; there is such a thing as a disordered liver in municipal life. We call it general apathy.

Not only is your duty that of looking after disease and of effecting a restoration of health, but, as we have heard tonight, you have a broader view, and that is, the prevention of disease. Does it not seem also that the true citizen seeks not only to correct errors and reform abuses, but that he also seeks those conditions which shall render impossible these abuses and render unnecessary these reforms? A city grows very much like a man. The straggling huts which first marked this city of ours and first obtained a name for it, were certainly very much like that little infant which begins its existence with small appreciation of the things about it, and sometimes with very little promise of the future. A city grows and develops, it strengthens and it cultivates itself, and becomes a center of influence and of material prosperity, just as the man does in his growth. It comes, then, to this: that as you are seeking the highest development of your profession and the highest standards of ethics to guide you in your relations with each other and with the community, so there is being cultivated in this community a growth of higher ideals of civic life, those higher ideals which shall lead the citizen to participate in the politics of his city in the truest sense; which shall drag him out of his home at night to attend the caucus for the

purpose of bringing about a change of things for the better; which will even induce him to accept office, at times much to his inconvenience, and yet because of his desire for the progress of his community—the community in which he lives—will he make this sacrifice. And it is in this direction that we are both laboring. It is toward these ideals we are looking; you toward the highest ideals in your profession, we toward the highest ideals in citizenship.

I will close my remarks with a sentiment which appears on the third page of this *menu* card. I misread it the first time: "I hold your dainties cheap, sir, and your *medicines* dear."

DR. EVERHARD: I do not know how large a part of this Society I represent, neither do I know how active non-resident members have been in the work of the Society, but if you have been good observers tonight you will agree with me that at a banquet or a good dinner we can be relied upon.

When I first had my attention directed to this toast, I supposed that it simply was a rather pretty and a delicately polite designation of the country doctor, but when I remembered my friends who were non-resident members from the thrifty little cities of Canton, Massillon, Akron and Youngstown, I thought it would require a brave toastmaster indeed who would dare announce such a toast with such a thought hidden in it. But Dr. Sherman seems to be the man. But whatever is implied in this subject it includes some of the best and most active physicians of northern Ohio, together with some other distinguished men from abroad. Now it is but natural that the physicians of northern Ohio should desire to be in association with the physicians of Cleveland. To us Cleveland is naturally a medical center, and we believe that you are in touch with other and still larger medical centers, and therefore we gain an advantage. For while today, perhaps, no man could be really or especially recognized to any great extent as authority in medicine or surgery, yet is not every man looking for a master? It has been said that in the whole domain of life every man is looking for a handier man than himself. I do believe that in every profession or art every man is looking for a master in that profession or art, one who can solve the difficulties which are too great for his powers.

But now with some embarrassment I see that it is not the physicians of northern Ohio alone who are having their faces turned toward Cleveland. Indeed, our patients do also. (Laughter.) I would not have you misunderstand that remark. Do not think I mean to say we do not have a good hold on our individual patients; but after all our patient comes to the city to have his throat or his nose treated; and he has a doctor for his nerves, and a specialist for his chest, and a surgeon for his appendicitis, and another surgeon for his joints, and an oculist for his eyes. Now we are really puzzled sometimes to know to what extent we ought to be responsible for the individual patient, when so small a fraction of him is under our care and advice. But when he comes back to us we always welcome him and carefully care for the remains. (Laughter and applause.) Gentlemen, I hope you will not misconstrue that; I mean what remains of the individual patient. For it will be forever true that there is one class of patients who all through their lives are almost cured but never are cured, and would not be cured because they enjoy their complaining so much. Then there is another class of patients who cannot be cured, but who gladly would. Now

both these patients always believe that if they could just find the man with the latest fad, or who has special skill in their malady, more should be done for them, more would be done for them; and thus they go on through life until they are really done for.

In our relations as resident and non-resident members, I certainly must confess that the obligation and advantage have been altogether on one side. If I had command of words I would be very glad here tonight in some fitting way to express my appreciation of this fact. The papers that have been read by distinguished members of the profession from abroad have been an inspiration to the entire profession; and they have placed under obligations not only the entire medical profession, but it seems to me the community who were active in procuring their presentation.

Gentlemen, I thank you for the honor conferred upon me, and I hope that in the future, when we get better acquainted, some of our non-resident members will feel encouraged to take part in your discussions.

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## Book-Reviews

**MANUAL OF GYNECOLOGY**—By Henry T. Byford, M. D., Professor of Gynecology and Clinical Gynecology in the College of Physicians and Surgeons of Chicago; Professor of Clinical Gynecology in the Woman's Medical School of Chicago. Containing two hundred and thirty-four illustrations, many of which are original. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut Street. 1895. \$2.50.

As a text-book for students, who, as we all appreciate, are so hard pressed for adequate time to devote to the special branches of medicine and surgery, this book is to be highly commended. There is, however, one chapter in the book which most markedly detracts from the general value of the whole. The use of the stem-pessary in overcoming flexions, and the misuse of the sound in the attempt to replace a retroflexed or retroverted uterus, ought to be on all occasions condemned. No instrument in the hands of careless or unskilled practitioners can be so prolific of pelvic disease as the sound or other repositor. How many physicians use any antiseptic precautions in their general office work? Sponge and laminaria tents are also becoming less and less used, and ought to be wholly abandoned. Too little space is given to the various uses in which the knee chest posture can be applied in pelvic work—a measure which is probably less pyrotechnic as well as less harmful than the adoption of the “master's stroke.”

Numerous cuts from Winckel, Schroeder and others including some original work of the author, illustrative of the text, abound.

The “older” practitioner will probably apply to one of the larger and more complete works to further increase the knowledge gained in actual work; this book is very well adapted to the student in conjunction with his lectures, clinics and ward classes.

O. T. T.



A MANUAL OF PHYSIOLOGY, WITH PRACTICAL EXERCISES.—By G. N. Stewart, M. A., D. Sc., M. D. Edin., D. P. H. Camb., of Downing College, Cambridge; Professor of Physiology in the Western Reserve University, Cleveland; formerly George Henry Lewes student; Examiner in Physiology in the University of Aberdeen; Senior Demonstrator of Physiology in the Owens College, Victoria University, etc. With numerous illustrations, including five colored plates. University Series, London: Baillière, Tindall & Cox, 21-22 King William Street, Strand, 1895.

It is an especial pleasure to review this work of Professor Stewart's for two reasons; first, because it is the best text-book of physiology that has come to our notice, and second, because it is the work of a Cleveland author. Cleveland has little in her past record of scientific work and production to be proud of, and the new era is but dawning. This Manual of Physiology is of such great merit that it will stand in medical history as the best work by a Cleveland author for many a year to come.

The work consists of nearly 800 pages, excellently printed upon good paper, while the binding, done in Cleveland, is indifferent. The work is well-illustrated, and in particular there are five colored plates whose beauty and accuracy are of the very highest order. The diction is of the purest English, and the author's meaning is always so clear that a few natural Briticisms will be condoned by the American reader. This manual if properly introduced to the teachers of advanced physiology in this country will certainly become one of the leading text-books.

Large sections of "Practical Exercises" are placed at convenient intervals throughout the book, thus segregating the practical from the didactic work and rendering it peculiarly available as a text-book.

It is impossible within the limits of a review article to convey a clear idea of the surpassing excellence of this work. So many good things are to be found in it that it seems unjust to point out only a few of them, and likewise it seems a pity to call attention to the few errors.

Chapter IV upon Digestion, Chapter V upon Absorption, Chapter VI upon Excretion, and Chapter VII upon Metabolism, Nutrition and Dietetics comprise the most concise and, in the main, the most modern views upon these important practical subjects that are to be found in any recent physiology.

The ubiquitous manufacturing chemists will hotly rebel from the following statement: "It is doubtful whether even one of the ferments of the digestive juices has as yet been satisfactorily isolated." The reviewer, however, is not inclined to quarrel with the statement.

Professor Stewart ascribes some active and benign part in digestion to the microorganisms of the alimentary canal, and believes they play a definite part in digestion, probably producing some of the so-called unorganized ferments. Professor Stewart sets right a misapprehension of the reaction of the intestinal canal which is persistently taught by physiologists today, namely: "The common statement that the contents of the intestine are alkaline is certainly incorrect. Trypsin, like pepsin, performs its work for the most part, at any rate, in an acid medium. \* \* \* The acidity of chyme continually increases as it passes down the gut." This on page 307

After reading and commending the above it is a little mystifying to read on page 309: "The *succus entericus* plays no very important part, though, as an alkaline liquid, it doubtless aids in establishing the reaction favorable to intestinal digestion." It is also curious that in speaking of the composition of feces (page 311) no mention is made of the bacterial content, though on the previous page they are said to "swarm in the feces." But the determinations of Von Jaksch, Nothnagel and others, that two-thirds of the feces are made up of bacteria certainly deserve specific mention.

The figment going the rounds of the European and American journals lately, countenanced even by Osler, that little or no absorption occurs in the stomach, finds no favor in this work. We are told that peptones, sugar and diffusible substances are absorbed by the stomach. In the face of abundant clinical observation of the physiologic effects of such drugs as morphin and alcohol exerted in from 15 to 30 minutes after ingestion, the statements of a physiologist are really hardly necessary to dispose of this fable.

It could be wished that the author had used the proper and exact chemical term "carbon dioxid," instead of the incorrect and ambiguous term "carbonic acid."

On page 330 occurs the following statement: "The feces represent chiefly unabsorbed portions of the food. A small and variable contribution is that of the expectorated [!] matter," etc.

Professor Stewart becomes humorous over the discomfiture of a surgeon who "with a natural impatience of loose odds and ends of this sort," exultingly removed a floating kidney from a woman who had only been provided with one renal organ.

The reader notes with some surprise on page 360 that the author, in comparing sweat and urine, says: "But the broad difference stands out clearly enough, and the reason of it lies, perhaps, in the essentially different purpose of the two secretions." This may be merely a rhetorical flourish, but to ascribe purpose to the secretory cells (or any other cells, for that matter) of the body does not comport well with modern views of biology.

Curiously enough Dr. Stewart has been led by the wily surgeons into using an expression which is yet incapable of passing muster as English, *i. e.*: "in the *operated* goose," "of the *operated* animal," Page 377.

It is pleasing to find the statement that leucin, which is almost constantly formed in the intestine, can be transformed into urea in the body. Dr. Stewart concludes that there is no evidence to prove that uric acid lies on the direct line from proteid to urea, and in this agrees with the scientific workers in this line rather than the clinical observers. The author draws from a careful study of the much debated question of the location of the chief formation of urea, the following admirable conclusion: "From some tissues, and notably from muscles, the nitrogen does not pass out in the form of urea, but it appears in the urine mainly as urea, and the change is effected, to a large extent but not exclusively, in the liver."

Physicians need to remember "the first great law of nitrogenous metabolism: consumption of proteid is largely determined by supply." The second law is but little subordinate in importance: "Nitrogenous metabolism is nearly independent of muscular work." Although this statement is the conclusion of almost all investigators in this line of work, it has not yet filtered out very far among the medical profession.

In spite of numerous recent denials, Professor Stewart agrees with Pepper and the older writers that part of the ingested chlorid of sodium is broken up to form the hydrochloric acid of the stomach. Many recent writers upon diseases of the stomach would have us believe that the animal body can manufacture a chemical element—chlorin—out of nothing, because while denying that the Cl of the gastric H Cl is formed from ingested Na Cl, they fail to say from whence the body draws its mystic supply of Cl. The author also gives an admirable reason for the necessity of man using salt with his food. Meat contains sufficient salt for all purposes of its digestion, but with vegetables the case is different. Nearly all vegetables contain an excess of potassium phosphate, and in the body a double decomposition takes place between this salt and sodium chlorid, resulting in sodium phosphate and potassium chlorid. There is thus a constant demand for Na Cl to meet the drain of the body's supply from this source.

Professor Stewart's summary of the action and uses of alcohol is excellent. (1) In small quantities it is oxidized in the body, and is hence to some extent a food substance. (2) Heat is produced from its combustion in the tissues, but is more than counterbalanced by the loss from dilatation of the peripheral circulation which it causes. (3) It is a valuable drug in certain diseases. (4) It is useful in some cases of slow digestion. (5) It is of no use for healthy men. (6) In strictly moderate doses it is not harmful to healthy men. (7) It is injurious in severe exertion and in extremely hot or cold weather.

This must close an insufficient cursory review of the most charming text-book of Physiology in the English language. P. M. F.

VALUE OF FAMILY HISTORY AND PERSONAL CONDITION IN ESTIMATING A LIABILITY TO CONSUMPTION.—Published by the Mutual Life Insurance Company of New York, 1895.

This brochure of 23 beautifully printed quarto pages, is really a report upon this most interesting and important topic to the President of the Company, by E. J. Marsh, M. D., Medical Director.

The problem suggested is interesting to physicians as well as to actuaries. The experience of a large insurance company, extending over a long period of years, is unquestionably of the very highest value to the physician. It is devoutly to be wished that other insurance companies might largely follow this example set by the Mutual Life of New York, and have their records critically examined with a view of giving the medical profession the benefit of their experience.

Many and conflicting have been opinions of medical men upon the value to be given to a family taint of consumption, in estimating an applicant's insurability, or, sometimes, marriageability. The figures in this report are derived from 22,085 deaths from 1879 to 1893, and are therefore drawn from a large enough field to be worth something. The tables and diagrams illustrating the results of investigations of these records are well executed and easy of comprehension. The conclusions of this little monograph are all we have room to notice. It is of extreme interest to note that the tables indicate that: "The predisposition or tendency to consumption is rather a 'family' than an 'inherited' influence."

"The history of consumption in any members of the immediate family

increases by 30 percent the probability of its appearance in an applicant."

\* \* \* "Consumption in a brother or sister is at least of equal importance as when it has occurred in a parent." \* \* \* "Persons who are under the standard or average in weight are much more liable—really twice as liable—to consumption than those above this standard. The peculiarity of constitution which is indicated by the inability to take and assimilate a proper amount of nutriment indicates a susceptibility to phthisis, or at least a reasonable suspicion of such predisposition." "Persons who exhibit a robust and well-developed body have little susceptibility to consumption." \* \* \* "The evidence presented by a well-developed body may outweigh the suspicion attached to unfavorable family record." \* \* \* "These influences of family history and personal weight are of the same grade for every age, and their importance is not lessened by the fact that the individual has reached middle life."

An applicant's "personal condition is of the first and his family history of the second importance."

Each of these conclusions is of unusual interest to every physician and is worthy of a few moments' thought. As they are simple and direct deductions from a large series of facts no opinion in regard to them is called for. They represent the experience of this Company under the conditions named. It may be added, however, that these conclusions are in near accord with the teachings of the best writers of the day upon the subjects of pulmonary tuberculosis.

P. M. F.

#### HAND-BOOK OF THE DIAGNOSIS AND TREATMENT OF SKIN DISEASES.—

By Arthur Van Harlingen, Ph. B. (Yale), M. D. Published by P. Blakiston, Son & Company, Philadelphia, Pa., 1895.

The third edition of Dr. Van Harlingen's work is now given to the profession, enlarged to 577 pages. The diseases are arranged in alphabetic order, which avoids the attempt at any classification, and is brought abreast with modern knowledge. Of the various subjects treated, some are entirely rewritten and others more fully given than in the preceding editions. The most noteworthy addition, however, is in the form of numerous notes in finer type at the bottom of the page. In this way many citations are given and formulas added which make the book more useful as a work of ready reference.

We note that Dr. Van Harlingen still regards *Lupus Erythematosus* as a variety of tuberculosis of the skin and consequently allied to *Lupus Vulgaris*. We are surprised at this, for although the etiology of *Lupus Erythematosus* is ill-understood, modern investigation goes to show that it is in no way allied to *Lupus Vulgaris*, nor to tuberculosis of the skin. Much attention is given to differential diagnosis and the text is well supplied with numerous colored plates and wood-cuts. The volume closes with an appendix devoted to diet; this gives a list of foods found to be most wholesome, as well as questionable and objectionable articles of diet. Naturally the field cannot be fully covered in the space allotted to the various diseases of the skin, but we find it concisely written, and upon the whole, a valuable contribution to dermatology. It will be found especially useful to students and a book of easy reference to the general physician.

W. T. C.

**DIPHTHERIA AND ITS ASSOCIATES.**—By Lennox Browne, F. R. C. S. Ed., Senior Surgeon to the Central Throat, Nose and Ear Hospital; late President of the British Laryngological Association; Corresponding Fellow of the American Laryngological Association; author of "The Throat and Nose, and their Diseases," etc., etc. Illustrated by the author. London: Ballière, Tindall & Cox. Philadelphia: J. B. Lippincott Company. 1895.

This book of Lennox Browne's is a most excellent monograph upon Diphtheria, and deserves a place upon every physician's shelves. The subject is systematically dealt with and unusually good illustrations are provided. The disease is exhaustively discussed in all its bearings and from all standpoints. In pathology the writer accepts freely the conclusions of the modern workers, but, in the main, rejects the modern therapeutics. There is little to criticise in the book, but in order to present some intelligent idea of its scope and usefulness, it will be desirable to note a few of the salient features.

Three principal varieties of diphtheria are noted, *i. e.*, simple or bacillary, complex or cocco-bacillary, false or non-bacillary. The author recognizes no true diphtheria apart from the presence of the Klebs-Loeffler bacillus.

Atmospheric spread of the contagion is noted as very rare, which is in accordance with the best experience and renders prophylactic measures more hopeful. Impure water and from it contaminated milk is noted as the chief contagion-bearer. A parallelism in means of causation with those of typhoid-fever is noted, as well as many points of resemblance between the two diseases. It is impossible to agree with the author in boldly rejecting the mass of evidence which has proved sewer-gas to be free from bacteria, and in persistently clinging to the old superstition in regard to its role in the causation of this and other infectious diseases.

A notable conclusion of the author's from a very large experience, is that posterior adenoids and enlarged tonsils are the chief predisposing causes in the individual to diphtheria. These abnormal growths should be removed, even if the child has well-developed diphtheria. This is radical, perhaps, but is certainly founded upon sound reason.

An interesting theory of Sidney Martin's, accounting for the constitutional symptoms of the disease by supposing that the bacilli liberate a ferment which splits up the proteids of the body into poisonous substances, is noted.

An interesting observation is that the author has "never found a case in which membrane has been present in either nares or larynx in which the diphtheria bacillus has not been demonstrated to have been associated with either streptococci, staphylococci or both."

As above noted, the treatment recommended will seem a little antiquated, at least in some particulars, to American physicians. All will agree that treatment may well begin with a calomel purge, but that this should be followed by antimony, in a disease whose chief features, as the author is so many times at great pains to remark, is asthenia, will not meet with approval. Neither has the author been able to shake off the old superstition that the chlorates aid in body oxidation and are hence very useful.

He insists upon the early and free administration of iron. As a topical application, the author concludes, after careful trial of many remedies, that lactic acid is the most useful.

Croup, to our author, is laryngotracheal diphtheria, and nothing else. This is the Continental usage and is good. In no work will there be found a more concise or more accurate discussion of intubation and tracheotomy and the indications for each.

The most striking portion of the book is, of course, the discussion of the serum treatment, which is reserved for an appendix. The author's conclusions, derived from careful trial and under excellent conditions, are somewhat startling to the profession now so favorably inclined toward antitoxin. In his hands the mortality from diphtheria has not been decreased from the serum treatment, and he has found convalescence markedly delayed by its use. Skin eruptions and joint pains, probably septic, he found very much more frequent from the use of antitoxin. Albuminuria occurred in larger amounts under this treatment, and there was much increased liability to anuria. "Our figures show a very considerable and undoubted increase in the proportion of cases of nephritis under serum treatment as compared with the old." He quotes Baginski: "Paralysis is more frequent under antitoxin than before." The treatment has seemed to him to be decidedly depressant in its effects always. Further, "we do not feel justified in recommending serum as a prophylactic."

While this is the author's verdict from personal experience, he freely admits the more favorable results of many others. Every physician will enjoy reading this book. Its pathology and clinical description of diphtheria are the best we have read, and the book is worth buying for those two sections alone.

P. M. F.

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## Books and Pamphlets Received

**PRINCIPLES OF SURGERY**, by N. Senn, M. D., Ph. D., LL. D., Professor of Practice of Surgery and Clinical Surgery in Rush Medical College, Chicago; Professor of Surgery in the Chicago Polyclinic; Attending Surgeon to the Presbyterian Hospital; Surgeon-in-Chief to St. Joseph's Hospital; Ex-President American Surgical Association, etc., etc. Second Edition. Thoroughly Revised. Illustrated with 178 wood-engravings and 5 colored plates. Royal Octavo, pages xvi, 656. Extra cloth, \$4.50 net; sheep or half Russia, \$5.50 net. Philadelphia: The F. A. Davis Co., Publishers, 1914 and 1916 Cherry St.

**VALUE OF FAMILY HISTORY AND PERSONAL CONDITION IN ESTIMATING A LIABILITY TO CONSUMPTION**, published by The Mutual Life Insurance Company of New York, 1895. From the publishers.

*Fragilitas Ossium*, illustrated by a case, by H. C. Eyman, M. D., Medical Superintendent Cleveland State Hospital, Cleveland, O.

**THE OPERATIVE TREATMENT OF *Fistula in Ano***, by Lewis H. Adler, Jr., M. D., Instructor in diseases of the rectum in the Philadelphia Polyclinic and College for Graduates in Medicine. Reprinted from the *International Medical Magazine* for October, 1892.

- EXCISION OF THE COCCYX FOR CONSTANT PAIN RESULTING FROM AN UNUNITED FRACTURE**, by Lewis H. Adler, Jr., M. D. Reprinted from the *Medical News*, September 28, 1895.
- THE ETIOLOGY AND SYMPTOMATOLOGY OF *Pruritus Ani***, by Lewis H. Adler, Jr., M. D. Reprinted from the *Philadelphia Polyclinic*, Vol. IV, Sept. 28th, Oct. 26th, Dec. 14th, 1895.
- DIPHTHERIA ANTITOXIN**, "BEHRING," Guaranteed under official seal by the Imperial German Government. Sole Agents and Licensees for the United States, Schulze-Berge & Koechl, 79 Murray Street, New York.
- DR. KING'S MEDICAL PRESCRIPTIONS**, containing the favorite formulas of the most eminent medical authorities, collected from their published writings, by John H. King, M. D. Second edition, New York, Bailey & Fairchild Company, 1896.
- TRANSACTIONS OF THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA**. Forty-second annual meeting held at Goldsboro, N. C., May 14th, 15th and 16th, 1895. Wilmington, N. C., LeGwin Bros., Printers and Binders, 1895.
- A SYSTEM OF GYNECOLOGY** with three hundred and fifty-nine illustrations; based upon a translation from the French of Samuel Pozzi. Revised by Curtis M. Beebe, M. D., Chicago, Ill., 1894. J. B. Flint & Company, New York.

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### Medical News

**Dr. and Mrs. Wm. H. Humiston** gave a very pleasant reception on Tuesday evening, January 7th, at their home, No. 1008 Willson Avenue.

**Dr. John P. Sawyer** and **Dr. Hunter Robb** have each within the last few weeks been blessed by the addition to the family circle of a son and heir.

**Dr. Fox**, while in town, was the guest of **Dr. W. T. Corlett**. From here **Dr. Fox** went to Detroit, where he delivered a lecture before returning to New York.

**Dr. Dudley P. Allen** and **Mrs. Allen** have been spending a few weeks in Bermuda. They sailed for New York on January 13th, and reached Cleveland on the 20th.

**Dr. Dan Milliken** of Hamilton, Ohio, is in the lecture field with the following lectures: *The Under Man*; *An Inherited Estate*; *Human Automatism*; *Dreamers and Dreaming*; *The Mechanism of Memory*.

**The many friends** of **Dr. A. D. Campbell**, of 1967 St. Clair Street, this city, will be very glad to know that he is recovering from the rather severe attack of typhoid-fever from which he has been suffering.

**A Fellowship** in Anatomy in honor of the late **Dr. Joseph Leidy** is to be established in the University of Pennsylvania. It is proposed to secure by subscription a fund of \$30,000.

**Dr. Wm. C. Berlin**, has recently been elected Demonstrator of Chemistry in the Wooster Medical College. Mr. Fred Harris, of Chicago, was also elected assistant curator in the same institution.

**Dr. C. F. Hoover** has just returned from a stay of over three weeks in Washington, where he has been using the library of the Surgeon-General's office in looking up some special subjects.

**Pediatrics** is the title of a new venture in the journalistic realm. owned by Dr. Dillon Brown of New York, and edited by Dr. George A. Carpenter, of London. Its title explains its field and the first number is a very creditable affair.

**Would be Good News** if it originated in Ohio. It is announced that of 76 applicants for license to practice medicine in Pennsylvania, examined at the last meeting of the State Board, 22 failed to make the required average and were refused license.

**Professor Johannes Gad** of Berlin, who spent a year in Cleveland as Professor of Physiology in the Western Reserve University, has been elected to the Chair of Physiology in the University of Prague, and has also been made Director of the Physiologic Institute.

**Dr. C. A. Hamann**, Professor of Anatomy in the Medical Department of Western Reserve University, spent a week of the Christmas vacation in the East, visiting Washington, Baltimore and Philadelphia, where he attended the meeting of the American Association of Anatomists.

**We are in receipt** of a neatly-executed "booklet" from the *Medical Fortnightly*, setting forth the value and advantage of that journal. Half-tone portraits of all the editorial staff occupy a large part of the "booklet." The *Fortnightly* is to be congratulated upon the neatness of this little brochure.

**The profession** will regret to learn that Dr. W. J. Scott has for several weeks been confined to his house by indisposition. All will certainly join in the wish to see him out again when more favorable weather obtains. During December he was actively engaged in practice as usual and probably overtaxed his strength.

**A medical journal** which begins life with the January, 1896, number is the *Peoria Medical Journal* which has just come to hand. It presents a very neat appearance and the indications point to a prosperous future for it. Wishing the new journal all success we extend to it the compliments of the New Year season.

**Announcement** is made of the resignation of Dr. H. Bronson Gee as editor of the *New York State Medical Reporter*, and of the succession to that position of Dr. Charles Wilson Ingraham, of Binghamton, N. Y. The paper will be published by the Medical Reporter Publishing Company, whose office will remain in Rochester.



**Dr. George Dock**, Professor of the Practice of Medicine and Pathology in the University of Michigan, has been elected Professor of Pathology and Bacteriology in Jefferson Medical College. Professor Dock is a graduate of the University of Pennsylvania, and was formerly Professor of Pathology in the University of Texas.—*Medical Record*.

**The report** of the Library Committee of the New York Academy of Medicine contains some very interesting features. Of medical journals it has on file 80 English, 7 (!) American, 140 French, 167 German, and other foreign journals 56. There are 33,140 volumes in the library, 2,039 having been added in 1895. The expenses of the library Committee for the year were \$5,458.

**The Pittsburg Academy of Medicine**, which was organized subsequent to the birth of the Cleveland Medical Society, and which was fashioned much after the plan of our own Society, will be addressed by Professor Hobart Hare, upon Friday evening, January 31st, in pursuance of the plan of bringing distinguished medical men from other cities to address the local profession. The credit of inaugurating this plan belongs admittedly to the Cleveland Medical Society.

**As the profession** was given to understand but a few months since that upon his retirement from the Army Medical Service, Dr. John S. Billings would devote his whole time to his position as Professor of Hygiene and Director of the Laboratory of Hygiene in the University of Pennsylvania, it is somewhat startling to meet the announcement that he has just been appointed Librarian of the New York Consolidated Library. This library, recently formed by the union of the Tilden, Lennox and Public Libraries, has now over 360,000 volumes and several millions of property.

**Dr. C. E. Cotton**, Professor of Anatomy, in the Medical Department of Wooster University, spent the holidays in Baltimore and Philadelphia. In Baltimore he looked carefully into the methods of obtaining dissecting material which prevail at Johns Hopkins University. He learned that that institution has as much difficulty in this regard as have the local colleges and that it is compelled to resort to means technically illegal to obtain sufficient material. In Philadelphia Dr. Cotton attended, in company with Dr. Hamann, the meeting of the American Association of Anatomists, of which he was elected a member.

**A large-sized half-tone engraving**, of a number of packages of certain pharmaceutical products was used by a large number of medical journals in their December and January numbers as a folded inset, with somewhat disastrous results. The trouble resulted from that section of the postal law which says that an inset in second class matter must be exactly the same size as the ordinary page of the publication. At least one journal was refused admission to the mail until the offending insets were torn out, and

several postmasters are busy explaining to the authorities at Washington how they came to admit the violation of the law.

**The World's Congress of Medico-Climatology** will hold a National Convention in San Antonio, Texas, February 20th, 21st and 22d, 1896. Each State medical society is empowered to appoint ten representatives to the Congress, and all physicians of good standing, who are accepted by the Committee on Membership, are eligible. A large attendance is expected at this meeting and the local officers promise that the entertainment afforded by the city of San Antonio will be of the very best. The scientific proceedings of the meeting will be of interest to all physicians, and a trip to the South at this time of year would be a delightful one.

**That the proceedings** of the Cleveland Medical Society are interesting reading to the medical profession not resident in Cleveland or northern Ohio, is abundantly indicated by the December number of *The Pacific Record of Medicine and Surgery*, which has just reached us. The first three pages of this number—and it is a large double-column journal—are occupied by the proceedings of the Cleveland Medical Society for the evening of October 11th last.

With the active, intelligent and energetic aid of a journal thoroughly in sympathy with its aims and purposes, the Cleveland Medical Society can hold with ease a prominent position among the best medical societies of the country.

**It is understood** that the arrangement between the present faculty of the medical department of Wooster University and the authorities of Ohio Wesleyan University, to which institution this faculty will soon be transferred, is such that the University agrees to see that all their new medical department chairs, including the practical ones, are properly endowed within ten years. At the end of this time the University authorities are to assume full control of the medical department.

The making of such a contract with the excellent prospect of its fulfillment augurs well for the future of Cleveland as a center of medical education. With both colleges well-endowed the permanence and increased efficiency of our schools is assured. The gentlemen composing the present faculty of the Wooster school are to be congratulated upon their good fortune.

**A happening of interest** to the medical profession is the arrest of Henry Griffin, janitor of the medical department of the Wooster University, on a charge of body-snatching. The cause was the removal of the body of Mrs. Mulloy from a grave in Calvary cemetery. Suspecting the medical colleges, the authorities at once instituted a search and discovered the body in the dissecting-room of the Wooster school. The janitor was arrested on a criminal charge and at the same time civil suit for damages

was entered against the school. This latter case the newspapers announced had been compromised by the payment of \$1,200.00 to the children of Mrs. Mulloy. It seems, however, that the attorney for the college had exceeded his authority, leading to an unfounded charge of bad faith against the college. This case illustrates well the result of the faulty laws in regard to the obtaining of bodies by the medical colleges which are in force in this State.

## Condensed Table of Mortality in Cleveland for December, 1895

By courtesy of Dr. J. L. Hess, Health Officer

### I—ZYMOTIC DISEASES

Measles .....	0
Scarlet Fever .....	1
Diphtheria .....	21
Croup .....	13
Whooping cough .....	2
Typhoid-fever .....	4
Cholera, cholera morbus and cholera infantum .....	2
Acute diarrhea .....	0
Chronic diarrhea .....	0
Dysentery .....	0
Cerebrospinal meningitis .....	7
Erysipelas .....	1
Malarial fever .....	1
Pyemia and septicemia .....	7
Alcoholism .....	1
Inanition .....	12

72

### II—CONSTITUTIONAL DISEASES

Cancer .....	16
Rheumatism and gout .....	3
Marasmus, scrofula and <i>tuberculosis mesenterica</i> .....	8
Hydrocephalus and tubercular meningitis .....	0
<i>Phthisis pulmonalis</i> .....	32
Anemia .....	0

59

### III—LOCAL DISEASES

Pneumonia and congestion of the lungs .....	34
Bronchitis, acute .....	7
Bronchitis, chronic .....	2
Tonsillitis .....	0
Pleurisy .....	0

Asthma .....	3
Congestion of brain and meninges .....	8
Apoplexy .....	11
Paralysis .....	8
Epilepsy .....	0
Tetanus .....	0
Convulsions .....	21
Other diseases of brain and cord .....	2
Diseases of heart .....	28
Aneurism .....	0
Abscess .....	2
Dropsy .....	5
Diabetes .....	2
Bright's disease .....	8
Peritonitis, gastritis and perforation .....	19
Hernia and obstruction of intestines .....	3
Diseases of liver .....	4
Genitourinary diseases .....	3
Hip disease .....	1

171

### IV—DEVELOPMENTAL DISEASES

Puerperal diseases not septic .....	0
Infantile debility .....	15
Dentition .....	1
Senectus .....	28

44

### V—DEATH BY VIOLENCE

Accidental .....	12
Homicide .....	0
Suicide .....	1

13

Total deaths for December, 1895. Total deaths for December, 1894, 423.

Annual death-rate per 1000 during the month (estimated population 325,000) 13.44+

# Cleveland Journal of Medicine

VOL. I

MARCH, 1896

No. 3

## Antitoxin in Diphtheria

RETIRING PRESIDENT'S ADDRESS

*Delivered before the Union Medical Association of Northeastern Ohio*

BY L. S. EBRIGHT, M. D., AKRON

*Mr. President, and Gentlemen of the Association :*

THE medical profession is to be congratulated upon the fact that it has kept pace with the progressive spirit of the age, and that medicine is rapidly taking its place among the exact sciences. In no manner is this better or more clearly illustrated than in the discovery and application of serum therapy in the treatment of those diseases which are the cause of so much dread to the laity and of anxiety to the profession. Its application in the treatment of diphtheria has, perhaps, caused more discussion in the public prints and among the members of the medical world than any of the others. That too much has been claimed for it there can be little doubt; that the expectations of its advocates have not been wholly realized, and that many are still skeptical, while others are perfectly convinced of its utter worthlessness, is true; it yet remains as one of the advances in medicine and a discovery from which much is to be hoped, and which will add additional luster to the crown of those who have wrought in this direction. The application of serum therapy to the treatment of diphtheria has engaged my personal attention, and I crave your indulgence while I report to you in this paper a number of cases which I had the good or bad fortune to see in March, 1895. I was much interested, and I may add, somewhat

alarmed, when I observed its action in my first cases. In every instance within from six to twelve hours there was an increased temperature, accelerated pulse, which was, however, changed in its character, having more tone, regularity and force. The temperature generally was very much modified in a few hours, said modification being ordinarily accompanied with a profuse perspiration. The kidneys in almost every instance were stimulated to increased activity, and the feeling of extreme lassitude, which accompanies the disease, soon gave place to one of strength and activity. Indeed, in all the cases that came under my observation the extreme depression was entirely absent after the first administration of the remedy.

My only excuse, gentlemen of the Association, for presenting these cases, in the place of a regular paper, is that from anything I might write you can neither gain any knowledge, nor in fact, be entertained, while I may indulge the hope at least that from the cases which I shall present to you you may be able to glean something to assist and cheer you in the future.

CASE I.—March 21st, 1895. Stephen Billings, an inmate of the Children's Home of Summit County, age 8 years, height 4 feet 5 inches, weight 50 pounds, dark complexion, bilious temperament; temperature  $102\frac{1}{2}$ , pulse 128. He complained of being tired, his bones ached, there was pain in the left ear, the tongue was coated, its tip red, the fauces were red and swollen. He vomited twice during the night, and there was almost constant nausea.

March 22d, 7:30 A. M. Temperature  $102\frac{1}{2}$ , pulse, 130. There was a grayish deposit on both tonsils; the uvula was not involved. A diagnosis of diphtheria was made. There was no bacteriologic examination until later.

R. Mercuric bichlorid was given in Fairchild's essence of pepsin,  $\frac{1}{16}$  grain to a drachm once in four hours, tincture of ferric chlorid 20 drops every four hours, and  $\frac{1}{80}$  grain of strychnin with whisky and milk. The appetite was poor, but as much nourishment was given as he could be induced to take during the attack.

March 23d. Deposit on the tonsils was spreading, the breath fetid, temperature  $102\frac{3}{4}$ , pulse 130.

The treatment was continued and sulphur calcine used with a spray, March 24th no improvement. The temperature and pulse were practically unchanged; 26th, temperature  $101\frac{1}{2}$ , pulse 126, throat apparently clearing; 27th, temperature  $101\frac{1}{2}$ , pulse 126; 28th, throat nearly cleared off, temperature  $101\frac{1}{2}$ , pulse 126; 29th, throat cleared off, temperature  $101\frac{1}{2}$ , pulse 120; 30th, temperature 101, pulse 118; April 1st, temperature, 100, pulse 112; 2d, temperature 100, pulse 110; 3rd, temperature  $99\frac{1}{2}$ , pulse 100; 4th, temperature 99, pulse 100; 5th,  $98\frac{3}{4}$ , pulse 100. On April 6th he was sent to

the intermediate hospital. April 7th a culture was taken from the throat and Klebs-Loeffler Bacilli found; he was then given 5cc. of antitoxin; no other treatment was employed.

CASE II.—L. W., aged 6 years, a sturdy lad with dark hair and dark complexion, had measles early in March and had a number of small boils. He was heard to cough a few times on Wednesday, March 27th, but played with the other boys. The attendant was awakened at 2 A. M. on the morning of the 28th by a harsh strident croupy cough. I saw him at 6 A. M. the same day; the pulse was 140, the temperature was 104, respirations 36 per minute, heart's action feeble, tongue white and coated, the tip red, the tonsils and uvula covered with a grayish-white membrane. A diagnosis of laryngeal diphtheria was made and an unfavorable prognosis given. He was given stimulants, iron and strychnin, and on March 30th, at 10 A. M. Prof. Ohlmacher administered 20cc. of his antitoxin, notwithstanding the patient was nearly moribund. He apparently rallied somewhat for a few hours but died the same day, March 30th, at 5:30 P. M.

CASE III.—Minnie B., 11 years old, 4 ft. 10 in. high, weight 78 lbs. fair, muddy complexion, light hair and lymphatic temperament, was taken sick March 29th. Her temperature was  $101\frac{3}{4}$ , pulse 130. The tonsils and uvula were covered with a diphtheritic deposit, the cervical glands were swollen and sensitive. Bichlorid of mercury was given in essence of pepsin and tincture of ferric chlorid with sulphate of strychnin  $\frac{1}{80}$  gr. and whisky every four hours.

March 30th, at 9:45 A. M., the temperature was  $102\frac{3}{4}$ , the pulse 140 and the membrane increasing. Prof. Ohlmacher gave her 20cc. of antitoxin. March 31st, at 9:45 A. M., the temperature was  $99\frac{3}{4}$ , the pulse 130. The patches on the throat gave evidence of diminishing and looked shriveled with contracted edges. There was some glandular enlargement. I administered 20cc. of antitoxin. At 7:30 P. M. the temperature was  $102\frac{3}{4}$ , the pulse was 130. April 1st, 7:30 P. M., the temperature was  $100\frac{1}{4}$ , the pulse 126. The nurse reported free perspiration through the night. Inspection revealed that the throat had cleaned off perfectly at 6 P. M., the temperature was  $101\frac{3}{4}$ , the pulse 118; April 2d, at 7 A. M. the temperature was  $99\frac{3}{4}$ , pulse 94; same day, 6 P. M. temperature  $100\frac{3}{4}$ , pulse 102; he ate three good meals on this day; April 3rd, 7 A. M. temperature 99, pulse 90; same day, 6 P. M. temperature  $99\frac{3}{4}$ , pulse 96; April 4th, 7 A. M. temperature  $98\frac{1}{4}$ , pulse 86; same day, 6 P. M. temperature  $98\frac{3}{4}$ , pulse 80.

The patient complained of pain in the left knee and muscles of the inside of the thigh. A profuse erythema appeared on the 6th of April, but there was no rise of temperature or increase of pulse rate. Bacteriologic examination confirmed the diagnosis.

CASE IV.—E. L., aged 7, 3 ft. 9 in. high, 43 lbs. in weight, with black hair and dark complexion. He was attacked March 29th, and seen by me

at 7 A. M. His temperature was  $100\frac{1}{2}$ , and pulse 140. The tonsils and uvula were covered with membrane, the breath fetid, and there was a discharge from the nostrils, excoriating the upper lip; there was some enlargement of the glands, deglutition was difficult, appetite poor, heart's action feeble, respirations hurried, 28 per minute.

March 30th, at 7 A. M. the temperature was  $102\frac{1}{2}$ , the pulse 140; at 9:45 A. M., Prof. Ohlmacher injected 20cc. of his own preparation of antitoxin; March 31st, at 7 A. M. the temperature was  $99\frac{1}{2}$ , the pulse 124. The throat gave evidence of clearing off; I gave her 20cc. of the remedy; at 7:30 P. M. of the same day the temperature was  $102\frac{1}{2}$ , the pulse 140; April 1st, at 7:30 A. M. the temperature was 99, pulse 126, the throat clearing. The nurse reported a good night after 12 M., with profuse perspiration; at 6 P. M. of the same day the temperature was 99, pulse 116, the appetite good; three hearty meals were eaten; April 2nd, at 7 A. M. the temperature was  $98\frac{1}{2}$ , the pulse 104; same day at 6 P. M. temperature  $99\frac{1}{2}$ , pulse 120; April 3rd, at 7 A. M. temperature  $98\frac{1}{2}$ , pulse 116; same day at 5 P. M. temperature  $99\frac{1}{2}$ , pulse 126; April 4th, at 7 A. M. temperature  $98\frac{1}{2}$ , pulse 100; same day at 6 P. M. temperature  $99\frac{1}{2}$ , pulse 108; April 5th, at 7 A. M. temperature  $98\frac{1}{2}$ , pulse 98; same day at 6 P. M. temperature  $99\frac{1}{2}$ , pulse 92; April 6th, at 7 A. M. temperature  $98\frac{1}{2}$ , pulse 108; same day at 6 P. M. temperature  $99\frac{1}{2}$ , pulse 120; April 7th, at 7 A. M. temperature  $98\frac{1}{2}$ , pulse 108; same day at 6 P. M. temperature  $98\frac{1}{2}$ , pulse 120; April 8th, 7 A. M. temperature  $98\frac{1}{2}$ , pulse 108; same day at 6 P. M. temperature 99, pulse 98; April 9th, at 7 A. M. temperature  $98\frac{1}{2}$ , pulse 100; same day at 6 P. M. temperature 99, pulse 110; erythema appeared; April 10th, at 7 A. M. temperature  $98\frac{1}{2}$ , pulse 104; same day at 6 P. M. temperature  $99\frac{1}{2}$ , pulse 106; April 11th, at 7 A. M. temperature  $100\frac{1}{2}$ , pulse 100; same day at 5 P. M. temperature 100, pulse 94; the erythema has disappeared; April 12th, at 6 A. M. temperature  $98\frac{1}{2}$ , pulse 100; same day at 6 P. M. temperature  $98\frac{1}{2}$ , pulse 98; April 13th, at 6 A. M. temperature  $98\frac{1}{2}$ , pulse 86; there was no rise in temperature after this date. This patient ate three hearty meals each day after the third day of the attack and her continued rapid pulse was undoubtedly due to the toxemia which was apparent from the onset of the disease.

CASE V.—F. D., age 10, 4 feet 3 inches in height, weighs 59 lbs., a dark-haired, robust girl, felt ill on the morning of March 30, and was seen by me at 9 P. M. Her temperature was  $102\frac{1}{2}$ , the pulse was 116. The tonsils and uvula were covered with a diphtheritic deposit, respirations were hurried, the secretion of urine very much diminished. I administered 20 cc. of Prof. Ohlmacher's antitoxin. Slight perspiration followed at 6 A. M. of March 31. At 9:45 A. M. her temperature was  $102\frac{1}{2}$ , and pulse 120; March 31, at 7:30 P. M., her temperature was  $100\frac{1}{2}$ , and pulse 120. I gave 20 cc. of antitoxin; at 7:30 P. M. pulse 130, temperature  $100\frac{1}{2}$ . April 1, 7:30 A. M., temperature was 100, pulse 130. The nurse reported profuse

perspiration. The throat was clear, except a few shreds, which were readily washed off with peroxid of hydrogen used with a spray. April 1 at 6 P. M. the temperature was  $100\frac{3}{8}$ , the pulse 112; April 2, 7 A. M. temperature  $98\frac{3}{8}$ , pulse 88—she ate a hearty breakfast; same day, 6 P. M., temperature 99, pulse 106; April 3, 7 A. M., temperature  $98\frac{3}{8}$ , pulse 96; same day temperature was 99, pulse 100; April 4, 7 A. M., temperature 99, pulse 92; same day, 6 P. M., temperature  $99\frac{3}{8}$ , pulse 88; April 5, 7 A. M., temperature  $98\frac{3}{8}$ , pulse 80, erythema appeared; same day, 6 P. M., temperature  $99\frac{3}{8}$ , pulse 92; April 6, 7 A. M., temperature  $98\frac{3}{8}$ , pulse 94; same day, 6 P. M., temperature  $99\frac{3}{8}$ , pulse 94; April 7, 7 A. M.,  $98\frac{3}{8}$ , pulse 90. Erythema has disappeared. There was no rise in temperature after this date, although she was closely watched for a period of fifteen days.

CASE VI.—April 4—C. B., colored, aged 10, 4 feet  $4\frac{1}{2}$  inches high, 64 lbs. weight, a very sturdy lad, was seen by me at 1 P. M. His tongue was heavily coated. There was a well-marked deposit on both tonsils with fetid breath. The temperature was  $100\frac{3}{8}$ , the pulse 136; the heart's action was feeble. I gave him 10 cc. of antitoxin. At 6 P. M., the temperature was 100, the pulse 96; April 5, at 7 A. M., the temperature was  $98\frac{3}{8}$ , the pulse 96. The deposit on the throat had not spread. Notwithstanding the decrease in the temperature and pulse I gave him an additional 10 cc. of the remedy. At 7 P. M. his temperature was  $99\frac{1}{8}$  and pulse 108; April 6, 7 A. M., the temperature was  $100\frac{1}{8}$ , the pulse 110. The nurse reported a slight perspiration through the night. His throat was clear and he ate a hearty breakfast. April 6, 6 P. M., the temperature was 99 and pulse 114; April 7, 7 A. M., temperature  $99\frac{1}{8}$  and pulse 94; same day, 6 P. M., temperature 100, pulse 104; April 8, 7 A. M., temperature  $98\frac{3}{8}$ , pulse 98; same day, 6 P. M.,  $98\frac{3}{8}$ , pulse 98. After this date there was no rise in temperature, although for a period of eight days his pulse-rate varied from 80 to 100. It then became normal.

CASE VII.—April 5—I saw Jessie F., aged 12, 4 feet 4 inches high, with fair complexion, red hair, sanguine, nervous temperament. At 8 A. M. her temperature was  $101\frac{1}{8}$ , the pulse 128. The heart's action was feeble, the tongue coated, dirty white, the tips red; both tonsils were heavily coated, the uvula and nares not involved; the breath fetid. I administered 10 cc. of antitoxin. April 5, at 5 P. M., the temperature was  $103\frac{1}{8}$ , the pulse 129; April 6, 7 A. M., temperature  $100\frac{1}{8}$  and pulse 114. I gave 7 cc. of antitoxin. Same day, 5 P. M., temperature  $102\frac{3}{8}$  and pulse 132; April 7, 7 A. M., temperature  $100\frac{1}{8}$  and pulse 124. The throat at this time was clean. The nurse reported a good night with free perspiration; a hearty breakfast was eaten. April 7, at 6 P. M., the temperature was  $101\frac{1}{8}$  and the pulse 114; April 8, 7 A. M., temperature  $100\frac{3}{8}$  and pulse 102; same day, 6 P. M., temperature 102 and pulse 106; April 9, 7 A. M., temperature 100 and pulse 98; same day, 6 P. M., temperature 101 and pulse 112; April 10, 7 A. M., temperature 99 and pulse 100; same day, 6 P. M., temperature 101 and pulse



116; April 11, 7 A. M., temperature  $99\frac{1}{2}$  and pulse 88; same day, 6 P. M., temperature  $100\frac{1}{2}$  and pulse 104; April 12, 7 A. M., temperature 99 and pulse 98; same day, 6 P. M.,  $100\frac{1}{2}$  and pulse 98. Erythema had appeared. April 13, at 7 A. M., the temperature was  $98\frac{1}{2}$  and the pulse 80, from which time there has been no variation to May 1.

CASE VIII.—On April 10, at 7:30 A. M., I saw Freddie L., aged 5 years, weight 35 lbs., 3 feet 5 inches in height, dark hair, eyes and complexion. His temperature was 100 and pulse 120. The tongue was coated and there was a marked deposit on the tonsils and uvula. I administered 7 cc. of antitoxin. April 10, at 6 P. M., the temperature was 103 and pulse 142. The throat was not improved. April 11, at 7 A. M., temperature  $100\frac{1}{2}$  and pulse 122. He was given 10 cc. antitoxin. Same day, 6 P. M., temperature 100 and pulse 120; April 12, 7 A. M., temperature  $98\frac{1}{2}$  and pulse 120. The tongue and throat were clean. He ate heartily for breakfast. April 12, 6 P. M., temperature was  $99\frac{1}{2}$  and pulse 108; April 13, 7 A. M., temperature  $98\frac{1}{2}$  and pulse 96. There was no variation in temperature after this date. The pulse-rate varied for five days from 84 to 98, and there was slight erythema on the 17th of April.

CASE IX.—Lillie F., aged 15 years, 5 feet 2 inches high, weight 93 lbs., with fair complexion, abundant red hair, very kinky; nervous, sanguine temperament. She had had frequent attacks of tonsillitis, but was otherwise always healthy.

She was taken sick on April 11 and was seen by me at 9 P. M. of the same day. Her temperature was  $100\frac{1}{2}$ , and pulse 124; the tongue was heavily coated, the tonsils much swollen and highly inflamed. There were grayish patches on the tonsils and uvula and the breath was quite offensive. I administered 10 cc. of antitoxin.

April 12 at 7 A. M. her temperature was 102, her pulse 120; April 12, 6 P. M., temperature  $101\frac{1}{2}$ , pulse 120; her throat was clean though still red and swollen, with some enlargement of the glands. April 13, at 7 A. M. her temperature was 100, her pulse 100; same day, 6 P. M., her temperature was  $100\frac{1}{2}$ , her pulse 88, her appetite was good. April 14, 7 A. M., her temperature was  $99\frac{1}{2}$ , her pulse 92; same day, 6 P. M., temperature  $98\frac{1}{2}$ , pulse 86. April 15, 7 A. M., her temperature was  $98\frac{1}{2}$ , her pulse 80. There was no variation in temperature or pulse rate until April 18, when she had a very profuse erythema and her pulse was 96 for 12 hours.

CASE X.—Joseph M., aged 11, weight 62 pounds, 4 feet 7 inches tall, a rugged boy; dark hair, eyes and complexion, complained first on the evening of April 12, of being tired and legs aching; there was some nausea and sore throat.

April 13, at 1:30 P. M., the temperature was  $100\frac{1}{2}$ , the pulse 98. There was a deposit on the left tonsil, none on the right or uvula. I gave him 10 cc. of antitoxin; same day, at 4 P. M., temperature was  $101\frac{1}{2}$ , pulse 116.

April 14, 7 A. M., the temperature was  $98\frac{1}{2}$ , pulse 96; the nurse reported a good night. There was free perspiration, the throat was clean, and there was never any rise in temperature in this case, and the pulse gradually came to 78. On the 20th of April, 7 days after the antitoxin was administered he had a slight erythema.

CASE XI.—Bertie S., aged 4, weight 34 pounds, 3 feet 3 inches high, with dark hair, eyes and complexion, was found to be sick on the 12th of April. April 13, at 1:30 P. M., his temperature was  $100\frac{1}{2}$  and pulse 114. The tongue was coated and a deposit was diffused over both tonsils and uvula. I gave 10 c.c. of antitoxin. The temperature at 7 A. M. of the 14th was 99, the pulse 112, the throat cleaning off. At 6 P. M. of the 14th the temperature was 99, pulse 92. April 15, 7 A. M., the temperature was  $98\frac{1}{2}$ , the pulse 80, the throat was clean. There was no change in temperature or pulse-rate from this date. The appetite was good from the evening of the 14th.

CASE XII.—Nellie B., aged 9, reported sick on April 12. She was seen by me April 13, at 7 A. M. She had a fair, ruddy complexion, light hair, is 4 feet 3 inches in height, weighs 64 pounds. The tonsils were swollen, causing her speech to be thick, deglutition difficult; there was a grayish deposit on both tonsils and uvula, which was confluent; the temperature was 99, pulse 109. I gave 10 cc. of antitoxin. April 13, at 6 P. M., her temperature was 101, her pulse 114. April 14, 7 A. M., her temperature was 100, pulse 82, the throat was clean; same day, 6 P. M., her temperature was  $98\frac{1}{2}$ , pulse 78; her appetite was good. The temperature and pulse remained the same and she never complained of anything but pain in her stomach after eating. She had a profuse erythema on the 19th.

CASE XIII.—Maud M., aged 10, weight 61 pounds, 4 feet 3 inches in height, with dark hair, eyes and complexion, was seen April 14, at 2 P. M. The tongue was coated, the tonsils enlarged, with a deposit on both, and the uvula involved. Her breath was fetid and heart's action weak. The temperature was  $100\frac{1}{2}$ , the pulse 120. I gave her 5 cc. of antitoxin.

April 15, at 7 A. M., her temperature was 99 and pulse 96; same day, 6 P. M., temperature 99, pulse 98; the throat was clean; there was no odor to the breath. April 16, 7 A. M., her temperature was  $98\frac{1}{2}$ , pulse 80; appetite was good from that date; there was no variation in temperature or pulse. On the ninth day she had a slight erythema.

CASE XIV.—Mary McD., aged 23, 5 feet 7 inches in height, weight 137 pounds, exceedingly dark complexion, teeth all decayed and filled, felt tired on April 13; awoke on the morning of the 14th, at 2 A. M., with sore throat and a feeling of extreme prostration, and was seen by me at 10 A. M. Her tongue was heavily coated, there was a deposit on the left side of the throat, one inch by  $\frac{3}{4}$  of an inch in area, the right tonsil was swollen, with numerous gray patches; the temperature was  $100\frac{1}{2}$ , the pulse 140, the heart's

action feeble. I administered 10 cc. of antitoxin. At 6 P. M. the nurse reported that she had fainted twice during the day and fainted when I attempted to examine her throat. Her breath was very offensive. I gave her 10 c.c. of antitoxin. April 15, at 7 A. M., her temperature was  $100\frac{3}{4}$ , pulse 96; she had perspired very profusely during the night. Same day, 6 P. M., temperature 101, pulse 96, the throat and breath improved. April 16, 7 A. M., her temperature was 99, pulse 80, and her strength was improved; same day, 6 P. M., temperature 100, pulse 96; she ate some dinner. April 17, 7 A. M., her temperature was 99, pulse 80, the throat was clean; she had her breakfast in bed, got up at 10 A. M. and said she felt better than she had for a week previous to her sickness. Same day, 6 P. M., temperature  $98\frac{3}{4}$ , pulse 74. There was never any variation in temperature or pulse from this date.

CASE XV.—Arthur B., colored, aged 16, weight 95 lbs., height 5 feet 4 inches, was taken sick April 19th; was seen the same day at 5 P. M. His tongue was heavily coated, and there was a marked deposit on both tonsils, but little constitutional disturbance. The temperature was 99 and pulse 110. He was given 7 cc. of antitoxin. April 20th at 7 A. M. his temperature was  $99\frac{3}{4}$ , pulse 100; same day, 6 P. M., his temperature was  $99\frac{1}{4}$ , pulse 90. April 21st at 7 P. M. his temperature was  $98\frac{3}{4}$ , pulse 84; throat was clean; same day, 6 P. M., his temperature was  $98\frac{3}{4}$ , pulse 86, appetite was good. April 22d at 7 A. M. his temperature was  $98\frac{3}{4}$ , pulse 80; his appetite was good.

CASE XVI.—Fred. P., aged 14, weight 85 lbs., was taken sick April 27th and was seen the same day at 8 A. M. His tongue was coated and both tonsils were covered with an exudate. His temperature was 103, and pulse 140. The heart's action was feeble. He was given 10 cc. of antitoxin. April 28th at 7 A. M. his temperature was 100, and pulse 110. April 29th at 7 A. M. his temperature was  $99\frac{1}{4}$ , and pulse 100; the throat was clean. April 30th at 7 A. M. his temperature was  $98\frac{3}{4}$ , and pulse 88; his appetite was good. May 1st at 7 A. M. his temperature was  $98\frac{3}{4}$ , and pulse 80; he says he is all right. There was no rise in temperature or pulse after this date.

These cases were all in the Summit Co. Children's Home, and the diagnosis in each case was verified by a bacteriologic examination.

CASE XVII.—John B., aged  $4\frac{1}{2}$ , a slight child, of fair complexion and light hair, was taken sick April 17. He was seen by me April 19 at 2:45 P. M. His tongue was coated, the left tonsil covered with a heavy exudate, the right tonsil and uvula involved but slightly. His temperature was 102, the pulse 116. I administered 5cc. of antitoxin. At 10 P. M. of the 19th he was in a profuse perspiration. April 20 at 9:45 A. M., the temperature was  $98\frac{3}{4}$ , the pulse 106. I gave 5 cc. of antitoxin. April 21, at 10:25 A. M., the temperature was  $98\frac{3}{4}$ , the pulse 102. The throat was clean. April 22,

at 4 P. M., the temperature was  $98\frac{2}{5}$ , the pulse 96. He played about the house. There was no change in temperature or pulse from this date.

CASE XVIII.—Bertha B., a delicate child, aged 8 years, of fair complexion and light hair, was taken sick April 23. She was seen the same day at 9:30 A. M. Her tongue was coated, and there was a slight exudate on both tonsils. The temperature was  $100\frac{4}{5}$ , the pulse 140. She has worn a Tracheotomy tube since January 19, 1895. I administered 5cc. of the antitoxin. On April 24 her mother reported that she had perspired freely from 4 P. M. of the 23d until about 10 P. M. When seen by me at 9:30 A. M. of the 24th, her tonsils had cleaned off, the temperature was normal and pulse was 100. Her appetite was good. There was no change in her temperature up to May 1st, although her pulse never came below 90, owing undoubtedly to the presence of the tube.

CASE XIX.—May B., aged 6 years, a very rugged child, of fair complexion and light hair, was seen by me in counsel with Dr. R. The following history was elicited: Some twenty days previously a sister four years old had been treated for membranous croup and died after 4 or 5 days' illness. The nurse was attacked with what was diagnosed as diphtheria; April 29 May was taken sick with fever and sore throat. I saw her May 1st, at 4 P. M. Her temperature was then 104 and pulse 140, her tongue coated; there was an exudate on both tonsils as large as a ten-cent piece. I gave her 7cc. of antitoxin. She was seen by me at 4 P. M., May 2. I gave her 7cc. of antitoxin. Her mother reported a good night. The membrane was retracted and looked shriveled; her temperature was 99, and pulse 108. She was seen again at 12 M., on May 3. Her throat was clean, with the exception of a slight exudate on the right tonsil, not more than one-eighth of an inch in area. I ordered for her dinner fresh fish, fried potatoes and bread and milk, of which she partook so heartily that she informed her mother that she had the stomach ache. On May 5 she was playing about the house. A bacteriologic examination showed the Klebs-Loeffler bacilli.

CASE XX.—Ruth H., aged 21 months, was seen in counsel, and gave the following history. She had been sick three weeks with what had been diagnosed as indigestion. On Sunday the attending physician suspected diphtheria. The following Tuesday I saw her at 6 A. M. Her temperature was then  $102\frac{1}{5}$ , and her pulse 150. There was a marked exudate on both tonsils, a free muco-purulent discharge from both nostrils, and the mouth and throat were filled with mucus. Notwithstanding the unfavorable conditions I administered 5cc. of antitoxin. The following morning I saw her at 10 A. M. Her temperature was 100, her pulse 80, the skin warm and moist, and her finger nails pink, showing a good circulation. I gave the mother some encouragement. She was seen again at 8 P. M. the same day, when the mother and grandmother informed me that they had neither given her medicine, stimulants or food since noon, as they thought she would die.

I refused to have anything more to do with the case, and the child died on Saturday morning, four days after I first saw her. The attending physician reports that the child died from neglect.

In these latter cases a bacteriologic examination was made and the diagnosis of diphtheria confirmed. A number of other cases have been seen by me in counsel, but as a bacteriologic examination was not made I do not report them, although they were treated with antitoxin.

CASE XXI.—The mother brought J. M., aged 9 years, to my office April 3d. His family history was good. The boy was suffering from enlarged tonsils; there were no patches on the throat. The history suggested an ordinary tonsillitis, and I so prescribed. I had treated the boy at two different times before, within eighteen months, for tonsillitis. April 8th this boy's mother was suffering from malarial troubles, but no sore throat. At this time the boy was apparently in good health. He had been going to school and feeling well. The throat at this time appeared all right except that the tonsils were enlarged, as they had been since his first attack 18 months before. On April 13, the boy (J. M.) who had been apparently well until this day, again complained of sore throat. He had a high fever,  $104^{\circ}$ , a pulse of 140, and respiration 36. The tonsils were enlarged, nearly meeting. There were slight patches on each tonsil. The tongue was heavily furred, but there was no especial odor to the breath. I prescribed for the boy, supposing it to be simply an aggravation of the former tonsillitis and of malarial form. April 14 the throat was much worse, the temperature  $103\frac{1}{2}$ . The swelling had extended to both sides. There was much tenderness over the sterno-cleido-mastoid muscles. The throat was very red and the patches larger, but not on uvula or half-arches. There was complete anorexia and some prostration. Active cathartics were given with quinine and a gargle. On April 15 he was more prostrated. The tongue was heavily coated, the breath offensive, the temperature  $103^{\circ}$ . In the evening of the same day the patches had spread over both arches and uvula. The temperature was  $103\frac{1}{2}$ , the breath more fetid. There were no indications of pus-formation. April 16 he was seen again at 9 A. M. He had passed a restless night; was restless and peevish and had not eaten. The throat was completely covered with a thick, dirty-yellow deposit, and the breath horribly offensive. The temperature was 103, the pulse 130, respiration 36. The kidneys were inactive, the skin dry and feverish. A bit of the membrane was taken and examined. An injection of 12 cc. of antitoxin was given him. His temperature had been up in the afternoon, and when I saw him it had dropped to  $101\frac{1}{2}$ . The skin was moist and he was resting well. April 17, at 9 A. M., he had rested well and taken some nourishment. He said he "felt pretty good." His temperature was  $100\frac{3}{8}$ , the pulse 96, respiration 26. The tongue was beginning to clean. The skin was soft and moist, the throat not sore, and the patches were beginning to loosen. He was given

10 cc. of antitoxin. In the evening he was sitting in a chair, and said he "was all right." About half the deposit had disappeared, and the tongue was about half clean. April 18, at 10 A. M., the boy was able to play about. There was no prostration, the heart's action was good, the temperature was 99 $\frac{2}{3}$ . He had partaken of a hearty breakfast of toast, milk and eggs. He was given 8 cc. of antitoxin. In the evening he was feeling apparently well, throat was nearly clean, excepting a spot about the size of a split pea on one side of the uvula. He had been up and about most of the day. April 19 the temperature was 99, the pulse 78. The throat was entirely clear. He had eaten heartily and slept well. The soreness and swelling were nearly gone. The boy seemed well and bright, with no evidences of any prostration. No further treatment was given except the iron and small doses of whisky, which were continued for three or four days. There was no return of deposit and no further treatment. This was a case that alarmed me from the first, and was a serious case that I fear would have proved fatal if antitoxin had not come to my rescue.

NOTE.—I am indebted to Dr. A. P. Ohlmacher for his assistance; also to Dr. J. V. Cleaver, for the report of the last case, which I saw with him.

## Pelvimetry: Its Importance in Obstetric Cases

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AS times and conditions change new problems arise and new methods must be adopted to meet them. This occurs in the practice of medicine just as in other lines of work. For too long a time the medical profession in America has accepted it as true that deformed pelves are very infrequent, so that their influence in obstetric cases has received but little consideration. The result of this has been suffering, permanent disability and sometimes loss of life on the part of both mother and child.

It is my purpose in this paper to show that conditions have changed, that pelvic deformities exist here almost to the same extent as in Germany, and that only by the routine use of the pelvimeter by the general practitioner can the above results be prevented, or at least diminished.

Sometimes, though rarely, we find very marked deformities. These may be easy of recognition. But there are many women who have even very serious deformities which can only be recognized by careful measurements of the pelvis.

In order that pelvimetry may be practiced to advantage there must be some standard with which our measurements may be compared. There

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are different conditions also which must be taken into consideration in measuring pelves, especially externally; though these will not have very great effect on the result, for, as will be shown later, it is not so much the particular measurements as their relations to each other which are important. Whether a patient is fleshy or not affects really only one diameter, the external conjugate; which, by itself, must not be given too great prominence. The height of the patient does not have as much influence as might be expected on the diameters, for a tall woman may have a small or large pelvis, and the same is true of the woman who is below the average height. Still, in any one case, all these conditions will have some bearing, and in making out the diameters they must be considered. The average or standard of diameters as given by Litzmann and adopted in Germany is, that all pelves with an external conjugate of 18 centimeters or 7.2 inches or less are contracted, and that a *conjugata vera* of  $9\frac{1}{2}$  centimeters or 3.8 inches is the limit at which a pelvis can be called normal<sup>1</sup>. By this standard there is a deformity in fourteen percent of the women confined in Germany. In America we cannot as yet give many statistics, for very few pelves are measured. As one writer says, "pelvimetry is in its infancy," and we have no measurements from which to make averages. Dr. Austin Flint<sup>2</sup> has analyzed the measurements of 6,000 women and with a standard a trifle less than the one above, he found deformities in 11.56 percent, which is but little below that in Germany. When we consider that thousands of foreigners are coming to America every year, we must not only accept Dr. Flint's figures as applicable to all our cities, but as being in a fair way to be increased before many years.

Most cases of deformity are from shortening of the conjugate diameters. The other diameters may be shortened also but this affects the diameter of the true pelvis but little. A knowledge of them, however, is almost indispensable in determining a deviation from the normal conjugate. These diameters are the distance between the anterior superior spines of the ilium and also between the crests of the ilium. The first of these, between the spines, is 26 c. m. or  $10\frac{1}{4}$  inches, and that between the crests is 29 c. m. or  $11\frac{1}{4}$  inches. As ordinarily given, the external conjugate is 20 c. m. or 8 inches. As has been said, the build of a patient will cause some difference in this last diameter, so that taken by itself it is well not to place too much reliance on it. Nor can we say that a pelvis is deformed if the other two are a little less than the standard, for unless it were very marked, if their proper relations to each other and the external conjugate is kept up, it could not be considered abnormal. Just as soon, however, as the diameter between the spines and that between the crests begin to approach each other in length, the one becoming longer or the other shorter, then, even though our measurement of the external conjugate should not vary much from the standard, we must look for a flattening of the pelvis.

These two diameters can be easily and accurately taken and there is no danger of a mistake being made.

It is well to take also the distance between the trochanters for it, if much changed from the average, which is 31 c. m. or  $12\frac{1}{4}$  inches, indicates deformity of the outlet. As this is not very frequent, no more time will be given to it. Should the first three diameters be found normal there will be no need of taking the internal conjugate before labor begins. At the time of labor examination will show in these cases if any irregularities exist, and if so they can be but very slight, so slight indeed that only expectant treatment will be needed. If, however, the relations are disturbed, the internal measurements should be taken just as soon as possible and for reasons to be given later. The lowest limit at which a true conjugate can be considered normal is, as already said,  $9\frac{1}{2}$  c. m. or 3.8 inches. Ordinarily it is placed at 10 c. m. or 4 inches. The diagonal conjugate is 12 c. m. or  $4\frac{3}{4}$  inches. From this must be deducted  $1\frac{1}{2}$  to 2 c. m. or  $\frac{5}{8}$  to  $\frac{3}{4}$  of an inch, to obtain the *vera*, according as the pubic bone is narrow or wide, or according to the angle at which it is inclined.

The manner of taking the diameters can only be stated in a very general way at this time. For the distance between the spines a point of the pelvimeter is taken in each hand and placed on each spine, the patient lying on her back. The points are carried outward till they touch the sides of the spines when firm pressure is made to get the bone measurement. Carrying the points backward we look for the widest measurement between the external lips of the crests, also a bone measurement. The external conjugate is more difficult to take accurately and is measured from the depression below the spine of the last lumbar vertebra to the middle of the superior border of the pubic symphysis. The internal conjugate is measured from the promontory of the sacrum to the under surface of the pubic symphysis. This is taken with the first and second fingers touching the edge of the promontory and marking with the nail of a finger of the other hand where the pubic bone comes in contact with the finger, and then measuring with the pelvimeter. Very little practice is needed to take all diameters accurately.

To still further show the importance of pelvimetry I wish to refer briefly to some of the injuries which may result where deformity exists.

We too often measure our success from the condition of our patients, children as well as mothers, at the time of discharging them a week or two after labor. If, on the other hand, we study the results as seen several months or years later, we may often find some suggestion which will prove of value in the treatment of all cases, but especially those presenting abnormalities. The results as seen in mothers are better known than those seen in children, for the injuries resulting from difficult labors are more manifest in the mothers. The relation of those same labors to injuries or suffering seen in children is too little thought of though just as important.



To these I wish especially to refer, as the very best reason for studying how difficult labors may be rendered less dangerous.

Winckel<sup>3</sup> says that 10 percent of all children born die before the 11th day. Of these  $\frac{1}{10}$  percent die during labor and  $3\frac{3}{10}$  percent from injuries received at that time. There are many deaths which occur soon after birth, the cause of which is not always plain, that are often reported as being due to weakness. Investigation is showing, however, that many of them are in reality due to hemorrhage resulting from injuries to the head received during birth. Many of the so-called congenital disorders are rather due to these hemorrhages, which according to Dercum<sup>4</sup>, in his book on "Nervous Diseases," have been repeatedly demonstrated as meningeal. They more frequently occur at the base of the brain in vertex presentations, and at the vertex of the brain in breech presentations. Gowers,<sup>5</sup> in his "Diseases of the Nervous System," claims that the injuries are due less frequently to the forceps than the dystocia which makes them necessary, and that an earlier use of instruments in cases of prolonged labor in the second stage would save children that are now lost.

Paralysis is another result of difficult labor, more frequently due to pressure of forceps blades and especially seen in the facial nerve and brachial plexus. Hemiplegia, epilepsy, idiocy and impaired cerebral development have all been found to occur as a result of injuries received at birth.

These are facts which cannot be overlooked. They demand that nothing be left untried which will lessen the mortality of four percent during the first eleven days, and the other damages which are often dreaded more than death.

That any one method will meet all these conditions cannot be expected, but I do believe that when a cause is so plain, an early knowledge of that cause will make it possible to escape the effects in many cases. This knowledge can only be gained by the routine practice of measuring the pelvis of every woman who is to be confined. I say every woman; perhaps those who have had a previous easy labor might be omitted, but those who have had any difficulty in a previous labor and every primipara should be carefully measured. I know that not all slightly deformed pelves cause trouble, but we do not know which one may, and a knowledge of the presence of a deformity makes possible a better prognosis than if we go ahead blindly.

Some one has well said that the thought of too many is only that the child must be gotten into the world in some way, with little thought of how it is to be done or the after effects to mother and child. Grandin and Jarman<sup>6</sup> in a recent work, in speaking of pelvimetry, say that "It is as safe to make a diagnosis of cardiac disease without examining over the area of the heart as to pretend to care properly for a woman during gestation and

at term without having made a thorough examination at as early a date of pregnancy as possible."

Measuring the pelvis, to make it most effective, must be accompanied with some estimate of the relation of the child's head to the mother's pelvis. This is not easy, but by practice one can tell very accurately what it is by palpation, combined examination and efforts to press the head into the brim of the pelvis. But all diameters can be taken after birth and if recorded may be of great value in a later labor. We know that there is a tendency for the bones of the head to become less compressible and sometimes the head is larger in succeeding labors. By knowing what it has been we can judge very well what it may be again, and act accordingly. There is said to be an instrument invented by Farabeuf which promises much in determining the diameter of a child's head before birth.

Schroeder<sup>7</sup> says that though we cannot reckon exactly the relation between the head and pelvis, yet the history and course of previous labors and especially the diameter of the heads of previous children will aid greatly in deciding probable conditions in a given case.

With these thoughts regarding the needs of greater thoroughness in attending a woman who has a deformity in her pelvis, I wish to give a few suggestions as to how the practice of pelvimetry will enable us to be more thorough and diminish the injuries to mother and child.

I cannot consider at what limit of diameters we shall do certain operations, for each operation is a subject for a paper by itself and other things must be considered besides diameters in such a discussion.

In the first place a knowledge that the diameters of a pelvis are contracted would enable the physician in attendance to treat expectantly and intelligently, being more careful than we sometimes are to keep the bladder and rectum emptied, which, if full, often cause obstruction. Pains could be stimulated if not of sufficient strength to force the head downwards, but especially would the fetal heart be watched as it alone will tell us how the child is being affected by the severe pains and when, if at all, it is necessary, for its good, to use any active interference. We would be more watchful for prolapse of the cord, a complication which occurs more frequently when the head cannot readily engage than when it can. We would be more watchful for a stretching of the lower uterine segment with its dangers of rupture of the uterus which also occurs more readily when the head cannot engage. If only moderately contracted we could be prepared to turn as a prophylactic measure before such a procedure is too late. Flint's statistics show better results with this operation than by high forceps. It is also more generally adopted in Europe than in America. This saves the mother from the dangers of repeated attempts at high-forceps deliveries and the child from the dangers of a prolonged labor and often the added danger of the pressure of forceps which must be applied later. One

word in passing may not be out of place as to the effects on the child where traction is not made in the axis of the pelvis when forceps are used. Murray<sup>8</sup> has shown that by the sliding of the parietal bones on the occipital and frontal bones the anterior-posterior diameter is compressed, but this is compensated for by lengthening of the vertical diameter. A failure to correctly use axis-traction prevents this compensation by forcing portions of the head against the sacrum or pubic bones and, though the child may finally be delivered, it is, many times, with an injury causing hemorrhage, paralysis or a fracture.

Secondly, an early examination of the pelvis would make it possible to decide early whether a child can be born without symphysiotomy or Caesarian section. An early decision would again save the child from the dangers of a prolonged labor and increase the prospects of securing a living child, almost the only reason why a Caesarian section should be made. The mother, too, would be saved from the dangers of a prolonged labor and repeated examinations and attempts to deliver and so be in better condition to stand such an operation if needed. It would also make less frequent the need of performing craniotomy. If this operation is performed on the dead child, it is, in most cases, on a child which has died of a severe labor, caused by a deformed pelvis, which was not recognized because not measured. It can be no better to let a child die in this manner and then do a craniotomy than to do the operation on a living child.

Thirdly, it would enable a physician to produce labor four to six weeks before term in cases of contracted pelvis, where previous labors had been difficult or fatal to the child. This is an operation not attended with the dangers of the capital operations and gives the most favorable results for mother and child. Dr. Davis, of Philadelphia, in an article on "Injuries and Diseases of the Newborn<sup>9</sup>," says: "Experience abundantly proves that most cases of severe hemorrhage arise where disproportion in the size between the fetus and the mother's pelvis exists. There can be no rational prophylaxis that does not rest upon an estimate of the mother's size and the relative size of the fetus. We can not too strongly urge that pelvimetry be uniformly practiced by obstetricians and as it becomes more general the induction of premature labor will render these cases more and more infrequent."

I wish to make a brief reference to a case which will show the value of pelvimetry and safety of this operation. It is one I was able to examine and watch in my work at Prague and shows better than any other I could choose, several of the points mentioned.

The patient had had two living children; her third one was only delivered after craniotomy, as was also the fourth, in this last especially attempts having failed to deliver by high forceps. This progressive increase in difficulty of her labors adds weight to what has been said regarding the changes

of the child's head, as there was no evidence of recent pelvic changes which would explain the increased difficulty. Pelvimetry showed the distance between the spines to be 26 c. m.,  $10\frac{1}{4}$  inches, which is normal. The distance between the crests was 27 c. m.,  $10\frac{5}{8}$  inches, two c. m. less than normal and a disturbance in the relation between the measurements of the two diameters, which indicates a flat pelvis. The external conjugate was 18 c. m.,  $7\frac{1}{8}$  inches, also shorter than normal and especially significant when taken in connection with the above diameters. The *conjugata diagonalis* was  $10\frac{1}{4}$  c. m., less than normal and gave a *vera* of  $8\frac{1}{2}$  c. m. or  $3\frac{1}{2}$  inches, one-half inch less than normal. The last menstruation was October 18, and time of predicted labor July 25. Six weeks before the time of labor, it was found that the child's head could be pressed into the inlet. Examination with the pelvimeter showed the distance from head to breech to be 20 c. m., which would give a length of 40 c. m. for the child. The average for this period is 46 c. m. and for term 50 c. m. or 20 inches. These figures indicated that the child would pass through the contracted pelvis with no more than ordinary dangers. The operation will not be described at this time. After thirty-six hours a living child was delivered which weighed 2660 gms. The average weight for this period is 2424 gms, and for term 3100 gms. or seven pounds. Its length was 46 c. m. or 18 inches, and head diameters as follows: Biparietal,  $8\frac{1}{2}$  c. m., being at six weeks before term just equal to the true conjugate; bitemporal 8 c. m.,  $3\frac{1}{8}$  inches; occipitontal and occipitofrontal, each 12 c. m.,  $4\frac{3}{4}$  inches, and suboccipito-bregmatic, 9 c. m. or  $3\frac{1}{2}$  inches. The mother made an excellent recovery and the child lived and was well nourished. I believe this case illustrates well several points I have made and that a similar case would promise like results.

To conclude then, the subject of pelvimetry has to do with two lives and should be considered of double importance. There is undoubted evidence that pelvic deformities do exist more largely than is usually supposed, and are the cause of the death of many children and of permanent injury to many others, as well as serious injury and great suffering to mothers. It must be plain that only the routine practice of pelvimetry can disclose these deformities and make possible the adoption of such methods as will terminate the labor favorably and safely to mother and child.

<sup>1</sup> Medical Record, Oct. 26, 1895

<sup>2</sup> Medical Record, Oct. 26, 1895

<sup>3</sup> Am. textbook of Diseases of Children

<sup>4</sup> Dercum's "Nervous Diseases," chapter on Cerebral Palsies of Childhood

<sup>5</sup> Gower's Diseases of the Nervous System, page 801

<sup>6</sup> "Pregnancy, Labor and the Puerperal State," page 31

<sup>7</sup> Schroeder's *Lehrbuch der Geburtshilfe*, page 303

<sup>8</sup> Am. Textbook of Diseases of Children

<sup>9</sup> Am. Textbook of Diseases of Children, page 83

## Physical Culture for Women

BY F. B. MINER, M. D., WARREN, O.

IN bringing this subject before this Society I hope to arouse at least a passing interest in a matter that I thoroughly believe is by far too much neglected by our profession. A very large part of our practice is among women and consists of diseases peculiar to that sex. Much has been thought, written and said about prophylaxis of diseases of all kinds, but especially of these diseases of women. Dress reform, the abuse of the corset, suspending the clothes from the hips, and the use of high-heeled shoes, have been discussed, and agitation along these lines has been eminently proper and not without results. There is no doubt that corsets are less worn, and those worn are not so tight as formerly in this country; that high-heeled shoes are almost unknown, and the shoulders are beginning to relieve the hips of their burden; and as a result the present generation of women is better qualified to take the woman's part in the struggle of life than those just passed and passing have been.

But is it not possible to accomplish greater results by beginning earlier in the lives of our women with our preventive measures? Why not endeavor to give them sounder, stronger bodies in which to start the sexual machinery going? Will not strong, muscular bodies, with tissues toughened by physical exercise, such as young men enjoy, go far toward preventing versions and flexions of the uterus, ovarian congestion and kindred affections? Will it not give them stronger nervous systems and more resistance to all forms of disease?

Much of the so-called female weakness originates in the school-room. Should not our school-teachers be required to have a more definite knowledge of anatomy and physiology before being allowed to take charge of a school including girls at or approaching puberty? Our public-school teachers have a great responsibility along this line; a responsibility that they are not meeting in most cases, because they are ignorant of that branch of work.

It has been the custom among parents to impress upon the minds of their girls at a very early age that they are girls, and that they must no longer run and race and romp with their brothers, because it is unladylike. They must play indoors with dolls and quiet games, must learn to be proper and nice, while the boys of their household are out of doors playing football or baseball, running races, and in innumerable ways using just as much fresh air as they can pass through their young lungs. What is the result? While these boys and girls start even, while they are equally healthy and strong the first five years of their lives, at the age of puberty the girls have fallen way behind. The boys are stalwart youths, accustom themselves to all manner of athletic performances, have appetites that never fail, are always full of life and seldom tired. How different the picture of their sisters! They have grown to be frail girls who can neither walk, stand nor sit for any length of time with comfort. Their only exercise is obtained from their piano practice. They have too little life to get out into the pure out-door atmosphere, and if a breath of fresh air should by any accident reach them, an attack of bronchitis is the result. Their appetite is never good, and wholesome food is a stranger to their stomachs; headache is an almost constant companion; their menstrual periods are times of more or less suffering, and often incapacitate them entirely for work for several days.

*Read before the Union Medical Association of Northeastern Ohio, at Akron, February 11, 1896*

Is the contrast a little overdrawn? Have we not all seen just such families as these, and many of them?

It surely was not according to the original purpose of the Creator that woman should be physically so greatly man's inferior. From her entire subjection and supposed inferiority to man during the period of his barbarity, she has risen to be his peer intellectually, and very far his superior morally; nor will it be long before she will take a place a little below him physically. And it is not only our privilege as physicians, but our duty, as well, to use our influence to hasten that day.

Experience during the last few years has proven that systematic physical exercise will do as much for the female body as for the male. A few years ago when it was proposed to give woman an opportunity to obtain a higher education, and to open the colleges for her to study alongside her brother, the cry was that she was not intellectually strong enough to compete with him in the class-room; but it did not take her long to show him that he would have to do his best work to keep even with her in his class-work. Then the objection was advanced that physically she was not equal to the prolonged strain of a college course. This was more nearly true, and many women have gone through college at the expense of their health. Indeed, it has been at the expense of health that many girls have gotten through or even into the high school. But soon the experiment was begun of giving her the same opportunity for the proper development of her body as was given her fellow students. In all the better colleges where women are educated, gymnasiums are established with well-trained physical directors and a certain amount of systematic physical work is required, under the watchful eye of these directors. And under this system many women have not only been able to complete the college course who doubtless would never have stood it without, but at the same time have undergone a wonderful physical development. From the colleges the idea of physical culture has spread among other women, until there is quite a number of gymnasiums now established for women.

There is no doubt that there are many opportunities for severe injury to women from gymnasium work. So there are among men, and yet we believe in the work for men if it is properly conducted. There may be greater possibilities of injury among women than among men, but there is no good thing in this world that is not liable to abuse.

That the physical culture as conducted at Vassar is a great benefit cannot be denied. Unless furnishing a certificate from the house physician excusing her from gymnasium work, every student is required to take a certain amount of class-work. Before going into the gymnasium thorough physical examination is made. Measurements of all parts of the body are taken, both as to size and strength. If any pathologic condition is found, the student is referred to the house physician. From these measurements the physical director determines the exact development of the person, and prescribes special exercises to develop every poorly developed part; and thus is built up a systematic development; the lung space is increased, the heart is strengthened, and with greater general development always comes a more perfect nervous condition, and the person is put upon a higher plane of health and vigor. Better health in women means stronger and better progeny, subject to better home care than is received by children of weakly mothers. Thus the next generation will receive a better start in life, both as to health and morality.

These gymnasium opportunities need not be confined to college girls. Every town could easily have a good practical gymnasium, if we, as physicians, would arouse ourselves to study its benefits and teach the people. Such a gymnasium need not be excessively expensive. A single wall machine, costing ten dollars, will develop not only every muscle in the arms and legs, but those of the trunk as well. The back gets its full share of development, as do the abdominal and side muscles. And these need special exercise in women to counteract hereditary weakness, the result of generation after generation putting on splints to do the work properly assigned to these trunk muscles. If corsets were discarded and these exercises systematically used, a very great improvement would be seen in the strength and endurance of women. With a slight modification of this machine we can get special exercise for the intercostal muscles, and with their development deeper, stronger breathing and less tendency to shortness of breath and lung affections. In calisthenics we get general or systemic results, greater tone is given to the whole muscular system, while the regular apparatus work gives development of muscle for which it is necessary that the muscle shall overcome resistance. All these exercises stimulate the heart's action and thereby the heart-muscle is developed and circulation improved. We have here also a natural remedy for that bane of womankind, constipation. Massage, with aid in other lines, is one of the best cures for chronic constipation. We have in gymnasium work the possibility of a natural massage of the abdominal contents by the abdominal muscles, similar to, but much more vigorous than that which we get in walking. These instances might be carried out almost indefinitely. We see them practically demonstrated over and over again in every gymnasium for men.

A ladies' gymnasium should be under the direct supervision of a physician who has himself a good knowledge of gymnasium work. By him a thorough examination of heart and lungs should be made and such other examination as he may see fit to make in each individual case. The work should be in charge of a well-qualified physical director, who should carefully take all necessary measurements, and with a special knowledge of the application of all apparatus for special development, should prescribe and direct the exercise of each case. Carefully carried out physical culture for women could not fail to be of very great utility. What is the vital difference between the male and female tissues that one will not take on development equally with the other? We feed them the same nitrogen, carbon, hydrogen, oxygen, phosphorus and lime. The chemist has never announced any difference in the combinations of these elements in the tissues of boys and girls. The anatomist has told us of no difference in the general formation of the body, its blood and nerve supply, nor has the histologist in the minute structure. The physiologist seems to take the human body with no distinction of sex in his treatment of the subject of waste and repair. Why, then, if their tissues are alike will the influences that affect the one for good or ill not affect the other likewise? If young men are benefited by proper physical culture why not young women as much? Thus is not the reasonable conclusion of the whole matter, that women are not strong because they are denied the opportunities of cultivating strength? And is it not our duty as the conservators of the health and strength of our fellowmen to study the subject of physical culture for women as we would study any therapeutic measure, from a practical standpoint?

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## EDITORIAL

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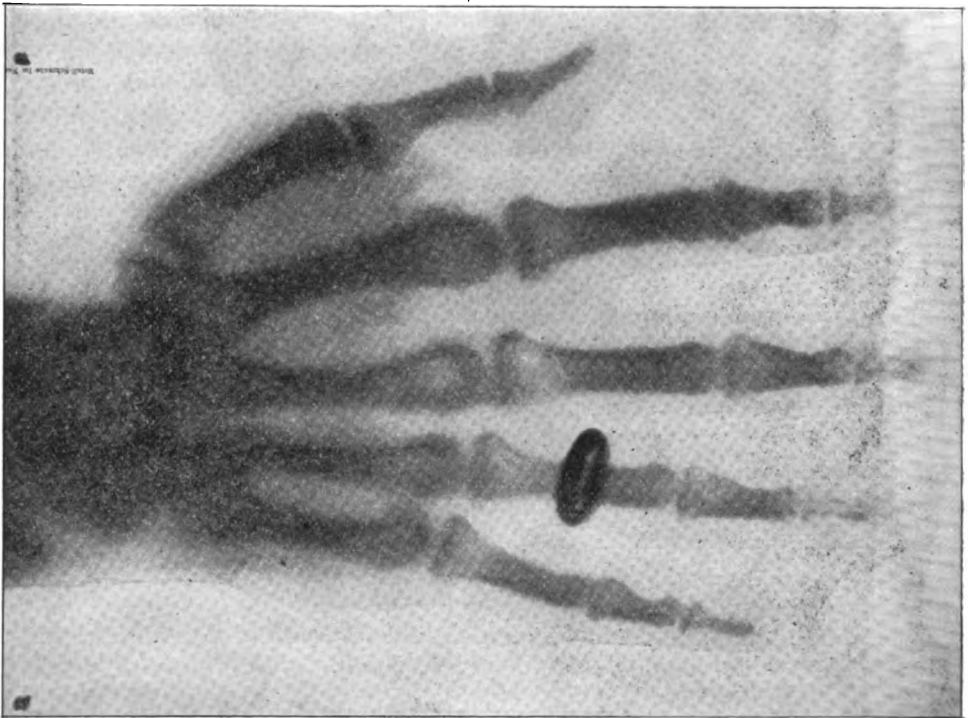
### The New Skotography

THE brilliant discovery of the already familiar X-rays by Röntgen opens so new a field in medicine that it is impossible to assign limits to its usefulness. The relations of the new skotography, as it has been aptly called (from *σκotos*, darkness, literally dark writing), to photography, are of especial interest. In brief, Professor Röntgen found that when the electric spark is passed through a tube exhausted as much as possible of air, in addition to the luminous phenomena with which all are familiar in the Geissler tubes, and the cathodal or ultraviolet rays



which have been already studied, rays of energy are evolved, invisible, and capable of traversing media impenetrable to light.

The method of skotographing an object is simple. For instance, the living hand is held between the Crookes tube which is the source of light and a photographic plate in a closed plateholder. The rays, unlike light-rays, travel in parallel straight lines, and are not, so far as is known, reflected or refracted. They travel straight through all known substances, but through some more readily than others; hence they reach the photographic plate



SKOTOGRAPH OF LIVING HUMAN HAND  
BY PROFESSOR ROENTGEN, WÜRZBURG

with more intensity through flesh than through bone, through bone than through metal; and the silver salt is reduced accordingly. The process is unlike photography, in that rays are not converged to form an image; on the other hand, the result is not a mere shadow, as would be the result if some substances were quite impenetrable to the rays. The process is like taking a print from a photographic negative in which there are different thicknesses of silver, allowing varying quantities of light to pass through.

There is produced a print of the hand which, unlike a photograph, takes account of the third dimension of space.

There is no reason why the process may not be improved so as to differentiate the organs of the body—liver from intestines, tumor from brain, and so forth, but this is still doubtful. We are glad to be able to give our readers a reproduction of a skotograph of the living human hand by Professor Röntgen. It will be seen that the flesh is apparently homogeneous, with no tracings of the blood-vessels and nerves. Up to the present time the metals and bone have been very successfully distinguished from the other tissues. It is possible that improvements may be made on the process for fifty years and more, as has been the case with photography. The field for research is one of the most attractive which has been opened in modern times.

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### The Attitude of the Cleveland Newspapers to the Kimmell Bill

IT is interesting and instructive to view the stand taken by our city papers in regard to the proposed medical legislation.

It is a pleasure to compliment the *Leader* upon its frank and manly stand in favor of a better educated medical profession and of preventing ignorant and unprincipled quacks from preying upon the public. The profession owes its sincere thanks to this paper, which, reaching the best class of our citizens, has had the courage to stand for truth and right despite the power and influence of the disreputable in medicine. The *Leader* is, in addition, to be highly commended for its steady refusal for a number of years to admit to its columns the advertisements of quacks and quack remedies. Few secular papers stand upon so high a plane in this matter.

The *Plain Dealer*, wisely remaining silent editorially, has continued its policy of printing all the quack advertisements it can secure and in the most offensive locations. It was also unfair enough to print a long letter from one of the most notorious quacks of the city, endeavoring to create sentiment against the Bill by misrepresentations, and to put in the waste basket everything that was sent it in rebuttal.

The *Press*, of course, has steadily opposed the Bill.

A new penny paper called the *Recorder* has been most venomous in its attacks upon the honor of the regular medical profession. Its arguments

had their main basis in false statements and their motive was so plain that they accomplished just the opposite effect from that which was intended. Honest objection to the proposed measure could have been respectfully received, but in reality its opposition was merely the voice of the demagogue appealing to ignorance and cheap prejudice to block the wheels of progress. As the editor of this paper is an enthusiastic devotee of "Christian science," (so-called), its attitude can hardly occasion surprise.

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### The Union Medical Association of Northeastern Ohio

IN no way has the progress of medicine been manifest of late years in this country more than in the growth of medical societies. A united profession means a strong profession; the diffusion of knowledge, the stimulus to exertion, the removal of narrowness and prejudice are furthered most rapidly by the medical society. The sphere of usefulness of any society is determined in the main by two factors: the average attendance at its meetings, and the publication of its proceedings. It must be evident that the latter may, nay, often does, make a vital difference in the usefulness of a society. Take as an example, the *British Medical Journal*, which is the official organ of the British Medical Association. Not only is the enormous influence of the *Journal* built on the proceedings of the Society, but the Society's proceedings reach and enlighten physicians all over the world, and are read by an audience at least a hundred times larger than the one which hears them. As a means to a lasting and wide success, the putting of a society's proceedings in permanent and attractive form is undoubtedly a *sine qua non*.

Of unusual importance, therefore, is the selection of the CLEVELAND JOURNAL OF MEDICINE, by the UNION MEDICAL ASSOCIATION OF NORTHEASTERN OHIO, as its official organ. This society has over 200 members, taken from the counties of Summit, Cuyahoga, Stark, Wayne, Medina, Trumbull, Holmes and Mahoning. The Society held at Akron, on February 11th, its ninety-eighth quarterly meeting. It is verging on the completion of a quarter of a century of useful work and is made up of the most representative men in the medical profession in this part of the State.

The result of such a union of Society and Journal is invariably mutual benefit. Interest in the meetings is stimulated; communications which are

to appear in print are carefully prepared; attendance on such meetings is sure to increase. On the other hand, in no way can a medical journal represent an organized profession so effectively as in just this way. The publishing of the official proceedings of societies interferes in no way with the independence of a journal; in fact in no other way can the whole profession be united and represented. The proceedings of two such societies as the Cleveland Medical Society and the Northeastern are of inestimable value, not only to the members of these organizations, but to those who are not enrolled among its members, and only by having them can the busy practitioner keep in touch with his contemporaries of this live and progressive portion of the medical world.

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### The Kimmell Bill

ON Wednesday, January 29th, 1896, the Kimmell Bill (the Mosgrove Bill of the former session) passed the House of Representatives of the State Legislature by a vote of 74 to 1. The debate previous to the passage of the bill was vigorous. Dr. J. A. Kimmell, of Findlay, Chairman of the Committee which had the bill in charge made the opening address. Rev. (?) Wm. C. Hutcheson, of Columbiana County, registered in the Seventy-second General Assembly as a *contractor*, followed with a bitter attack upon the bill. Hon. Van S. Deaton spoke warmly in favor of the proposed measure. Dr. James L. Hensley, of Marion, an eclectic physician, made one of the strongest speeches in favor of the bill. Hon. Robert Starr, aged 77, of Williams County, after sundry misunderstandings with his false teeth, which he finally discarded—much to the delectation of the gallery—made the most bitter attack upon the bill. Dr. David H. Reed, of Huron, and Dr. Rufus D. Jacobs, of Gallia, supported the bill strongly.

“At this juncture of the debate Mr. William A. Scott, Jr., an insurance agent from Fulton County, offered a number of amendments, during the discussion of which, Mr. Stewart, a lawyer from Clarke County, moved to postpone further debate until 2 P. M. the following day. Mr. Charles E. Hard, an attorney-at-law, from Scioto County, moved the previous question and demanded the call of the House. Both the efforts to amend and postpone were voted down by a large majority, and, after the call of the House, which showed 93 members present, there were 75 who answered to their

names when the roll was called, 74 of whom voted in the affirmative, while the toothless man stood solitary and alone against the bill."

An analysis of the vote is of interest. In the following list those of Cuyahoga's delegation of six who voted, have their names in large type: Yeas: Aker, Ashford, Baldwin, Beatty, Beckham, Bell, Bosler, Boxwell, BRAMLEY, BRECK, Conn, Cummings, Deaton, Dutton, Elder, Flummerfelt, Fosdick, Glenn, Goodale, Gray, Griffith, Hafer, Hard, Harris, Hazlett, Hensley, Hess, Heyde, Hinsdale, Huffman, Jacobs, Jones, Joyce, Kelly, Kimmell, Laub, Landis, Lutz, Lewis, McCauley, McGill, McLaughlin, McLean, MASON, Mayer, Means, Montgomery, Murphy, Myers, Norris, Parham, Redkey, Reed of Huron, Rice, Richardson, Robinson, Rochester, Rogers, Rusler, Rutherford, Schneider, Shuler, Southard, Stanbery, Stewart of Clarke, Stewart of Mahoning, Swingle, Tracy, Walton, Ward, Wiley, Wilhelm, Workman, Mr. Speaker—74. Nays: Mr. Starr—1.

We are indebted to the *Columbus Medical Journal* for much of the above account, its report being better than that of the daily press.

#### THE KIMMELL BILL BEFORE THE SENATE COMMITTEE

On Wednesday, February 5th, the Senate Committee of the State Legislature, to which had been referred the Kimmell Bill after it came over from the House, gave a public hearing to the advocates and opponents of the measure in the Senate Chamber. Senator W. T. Clark, of this city, was spokesman for the Committee. Cleveland was represented at this hearing by Drs. Tuckerman, W. E. Wirt and J. E. Cook, of the Cleveland Medical Society, and Drs. H. H. Baxter, G. N. Spencer and C. C. True, of the Cleveland Homeopathic Society. Other portions of the State were well represented, about 100 physicians in all being present. Twenty minutes' time was allotted to each school. Drs. Tuckerman and Baxter made very strong addresses. The Eclectics also spoke very vigorously in favor of the bill. The unanimity of the various schools of practice had a perceptible effect upon the committee. The Physio-Medicals had previously determined upon active opposition, but after extended explanations, when it came their turn to be heard; their spokesman announced their agreement with the other schools in this matter, and asked the committee to report the bill to the Senate without change. It is a pleasure to note that the Cleveland Medical Society delegation was instrumental in bringing about the final happy result.

The hearing of the opponents of the bill developed some very amusing situations. The two loudest of their speakers, after they had gone a little way, were asked by Senator Clark whether they were physicians. Each admitted that he was not. Senator Clark informed them that the hearing was for physicians only.

## FINAL PASSAGE OF THE BILL

On Wednesday, February 19th, at 2:30 P. M., the Kimmell Bill came before the Senate for passage as a special order. Senator William T. Clark, of Cleveland, who has been one of the bill's staunchest friends, and who deserves the hearty thanks of the medical profession for his efficient work in favor of the measure, in opening discussion upon the bill made an earnest speech in its favor. Senator Harbaugh, of Lucas County, having spoken strongly in favor of the bill, and no one else desiring to speak, the measure was put upon its passage. Not a vote was recorded against it. Thus, after twenty years' work a medical law is passed in Ohio with but one opposing vote in the whole Legislature. Why did success come at this time and not before? The answer is not difficult. The result is due to the thorough organization of the profession of the State, the medical societies of every county but two, Columbiana and one other, having strongly endorsed the measure and brought pressure upon the members of the Legislature. The cordial and vigorous aid of the other schools of medicine, the homeopathic, the eclectic, and after a misapprehension had been cleared up, the physio-medicals, was also an essential factor in the success of the movement. Although the medical colleges will profit greatly by the measure, they took no active part in its passage. The measure is the work of the profession at large through its medical societies and medical journals.

Although not by any means a perfect law, Ohio can at least congratulate herself that the future candidate for license to practice medicine in this State must have had a medical education. The ignorant quack has got to go. The educated quack will probably always be with us.

The Cleveland Medical Society has good reason to feel gratified at the passage of the law, as its attitude has been uncompromising in its favor, and it has worked early and late through its committees and officers to secure the enactment of the bill.

Ohio need no longer be ashamed of herself in this important particular. As the new Medical Practice Law by the terms of the bill went into effect at the time of its passage, and as all the physicians now practicing in the State must comply with the requirements of the law under penalty, a summary of its provisions will be of service. It may be noted in passing that the Governor must appoint the Board of Examination and Registration on or before the 19th day of March.

The Board consists of seven members, and the term is seven years, except the first seven years, which are so arranged that ultimately a new member shall be appointed each year. Persons now practicing must present their diplomas to the Board, accompanied by an affidavit that such diploma is their own rightful property. This presentation of diplomas may be done by proxy or by letter. A fee of \$5 must accompany the diploma with

the affidavit as aforesaid. Any person who has been illegally practicing medicine up to the time of the passage of this act must present a diploma or take an examination.

The Board having issued a certificate of right to practice, the physician must at once present it to the Probate Judge of his county and file with him a certified copy, paying a registration fee of 50 cents. The penalty for noncomplying with the terms of the law is \$200 to \$500 fine and 30 days to one year imprisonment in the county jail.

It will take a few months to get the Act and the Board in working order and the registration of existing practitioners completed. This adjustment to new conditions may be expected to give rise to considerable friction, but this is unavoidable, and no fault of the law. All physicians should promptly comply with the law, and when that is done they can, through their societies, set about the work of caring properly for the illegal practitioners in their neighborhood.

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### The Cleveland Medical Society

**F**EW, if any, medical societies in the country can show as enthusiastic and interesting a meeting as that of the Cleveland Medical Society on January 25th. Yet, although the attendance was over 80, the meeting differed little from the normal of this Society. The proceedings elsewhere in this JOURNAL will show that the scientific proceedings were of a most interesting and profitable character.

After the meeting the newly inaugurated President, Dr. J. E. Cook, following the precedent of his predecessors, entertained the society at a light lunch at Stranahan's. About 50 took advantage of his hospitality and some excellent speech-making occurred, which showed conclusively that the spirit of enthusiasm in the society is, if anything, more vigorous than ever. This year promises to be a very successful one for the society.

The address of the new President of the Cleveland Medical Society, published elsewhere, contains some very excellent suggestions for the future advancement of the society. The matter of sections is a vital one as the program is at present, and has been for some months, overfull. The counsel to the whole profession to work together in harmony for the advancement of Cleveland as a medical center is worthy of close attention. The suggestion that we at once take steps to learn the feasibility of obtaining at an early day permanent quarters for the society and its sections and for the library is timely. All would benefit by the consummation of this plan and it does not seem so chimerical at the present time as many might suppose. We hope the President's suggestions will be favorably acted upon and that they will stimulate the society to increased usefulness.

## Body-Snatching in Ohio

THE janitor of the medical department of Wooster (our contemporary misspells Worcester University) was recently arrested on a charge of body-snatching. The authorities discovered a stolen body in the dissecting-room of the school. The newspapers announced that the school had compromised in a civil suit by the payment of \$1,200.00, but the CLEVELAND JOURNAL OF MEDICINE states that this is not the case. "This incident" it adds, "is an illustration of the faulty medical laws of the State of Ohio," but we should infer that there was a screw loose somewhere else.—*Medical Record*.

Yes, in the coffin-lid admittedly.

The *Record* misquotes us, however, as we said "This case illustrates well the result of the faulty laws in regard to the obtaining of bodies by the medical colleges, which are in force in this State."

On February 22, suit for \$5,000 damages in this case was entered against Dr. C. B. Parker, M. Rosenwasser and C. E. Cotton of the Wooster Faculty.

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## As Others See Us

The first number of the CLEVELAND JOURNAL OF MEDICINE is out. It is owned and edited by Dr. Henry S. Upson and Dr. P. Maxwell Foshay and will be the official organ of the Cleveland Medical Society. This gives it high value from the start, for the members of the Society are the brightest and most progressive doctors in the city, and the reports of their cases and their investigations must, of necessity, be both interesting and helpful.

The above is from that bright and sparkling paper, *The Cleveland*, of January 25th. We extend both the thanks of the JOURNAL and of the Society to Mr. Sage for his complimentary words. We regret our inability to adequately reciprocate, as nothing we can say will increase the appreciation in which *The Cleveland* is held by the many physicians who are acquainted with it.

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## Paternalism

"It is reported that Emperor William had Prof. Roentgen rush from Wurzburg or Potsdam to give an illustrated lecture to the royal family on his alleged discovery of how to photograph the invisible, and bestowed on him the Order of the Crown, the same second-class decoration that Koch got."—*Medical News*.



## OFFICIAL PROCEEDINGS

OF THE

## Cleveland Medical Society

REGULAR MEETING JANUARY 24, 1896

*The President, DR. COOK, in the Chair*

The minutes of the last meeting were read and approved.

There were elected to membership Dr. L. K. Baker of Cleveland, and Dr. Carl Tuttle of Berlin Heights.

DR. W. T. CORLETT

*A case of pityriasis maculata et circinata*

In Duhring's cases the disease occurred in the adult. The cases reported from France and those that I have seen at the *Hopital St. Louis* in Paris, were almost invariably in children. Cases in England, reported by Crocker and others, have almost always occurred in children.

The case is of importance from a diagnostic standpoint, because I believe it is very important to recognize the disease. If we mistake it for syphilis we doom the patient for years, and probably for the remaining part of his life, to mercury and iodid of potassium, and worse than all, to syphilophobia. If we mistake it for psoriasis the mistake is of course a harmless one. But in regard to syphilis, the distribution of the eruption does not follow the lines that are so characteristic and which were shown so beautifully by Dr. Fox at the last meeting but one. It does not follow the ringed or horse-shoe shape of the syphilid. Again psoriasis does not usually occur over so extensive a surface, and it soon becomes covered with the characteristic silvery scales, so that the diagnosis might very readily be cleared up. One other point in regard to its diagnosis from syphilis; the mucous membranes in this disease are never disturbed.

Then again, in syphilis the upper part of the forehead, face, etc., almost invariably becomes implicated, especially the upper part of the forehead. In this case it extends, to a slight extent—or at least did extend—to the backs of the hands, not on the palms, and is limited to the parts covered by the clothing.

Broca, a few years ago, pointed out what he termed the initial lesion of *pityriasis rosè*, and which first appears on the upper trunk, and gradually disappears. Then the secondary or real eruption makes its appearance, starting on the upper part of the trunk, gradually working downwards, attacking the arms and finally the legs. The lesions tend to get well in the center. The margin here is prominent, the center is already disappearing and fawn-colored.

An interesting feature of the eruption tonight is that the disease is already beginning to disappear, and in the order in which it came. You notice the fawn-colored center which is on a level with the skin, while the margin is slightly raised. These brownish maculæ at the upper end of

the sternum were the first involved. Now as we go down the stain becomes more marked, the margin of a reddish tint, until on the lower extremity we get the characteristic rosaceous color of the disease itself. Here in the groin is a large plaque of a deeper red.

The microscope has failed to reveal any special micro-organisms. This patient has been subjected to an examination by Dr. Howard, who examined the scales carefully, but found nothing distinctive. Vidal found a micro-organism which he called *microsporon dispar*. Other observers have failed to confirm this observation. It is a self-limited disease, usually lasting from eight to twelve weeks.

### Dr. Cook's Address

**THE PRESIDENT:** The Society will permit me now, as incoming President to say a few words to them.

In beginning my duties to-night as your presiding officer for the coming year, permit me to again return my thanks for the compliment and honor which you have conferred upon me, and to say that it shall be my sincere desire to discharge the duties of that office with credit to myself and honor to the Society. In assuming this position I am confronted with a very marvelous record of growth and prosperity which this Society has attained during the past three years, dating from its birth, but I realize that to establish a still greater record of scientific growth and prosperity means a great deal of faithful hard work, not only on the part of your presiding officer and the different committees, but as well a firm determination on the part of each individual member to make the coming year the most influential and far-reaching of any in its history. The very advanced position which our Society has already taken among Medical Societies of the United States, and the many new and original ideas which have been suggested and carried into execution by my predecessors in office, leave your present presiding officer somewhat in doubt as to what, if any, suggestions can be made that will make this Society more expansive and progressive as a scientific and educational body. There are, however, a few suggestions that, to my mind, are feasible, and perhaps, in a sense, called for at this stage of our Society's existence. First and foremost in my mind is the question of sections. With the present large membership—and it shall be our constant desire to increase it, the growing desire of members, both resident and non-resident, to read papers, and the increasing number of clinical cases and pathologic specimens offered for discussion, lead one to believe that the time has come when we should at least consider the advisability of creating sections. Acting on this suggestion, I hope the Society will in the near future take this question up and give it a full and free discussion, and if sections are then deemed ill-advised at the present time, I should like the Society to discuss the question of weekly meetings in order that this vast amount of clinical material offered may be disposed of, and that more of our members may be given the opportunity of reading papers and taking part in the discussions. It seems to me that this question is of sufficient importance to deserve extended discussion at our hands, and I would recommend that as three weeks intervene between this meeting and the next, a special meeting be called, or if the Society prefer, a part

of the next regular meeting might be devoted to this purpose. A special meeting, it seems to me, would be preferable, owing to the importance of the subject, and my reluctance to encroaching upon the program of a regular meeting. This is, perhaps, not an original or new idea, for the question of sections was talked of in connection with the organization of this Society; but it seems to me the time has now come to carry into execution this early and much cherished plan. If the question of sections is looked upon favorably, I would suggest the formation of a surgical and gynecologic section, because the amount of surgical and gynecologic material offered the Society has become so great that it seems necessary to devote more time to these departments than can be given at our regular meetings. I believe it is also well to carefully consider the advisability of a pathologic section, and perhaps in connection with this, discuss the question of establishing a pathologic museum that shall be the property of this society. Let each specimen of special interest be given to the pathologist of this Society, and make it a part of his duties to superintend the progress and preserving of the same. These specimens, if the Society so will, can be used by the colleges for the purpose of medical teaching. In this way we can form a nucleus for a pathologic museum, which in time will be of vast importance to the teaching part of our fraternity.

If this plan of creating sections is found to be advisable, I believe that each individual member of this Society should be considered a member of the different sections, in so far as attending their meetings and being allowed the privilege of discussion are concerned, but that each section should have its own organization, and should control the same. I see only one danger in the organization of sections, and that is the possible loss of interest in the mother Society by those whose special interest will be in sectional work; but I trust and believe that your interest and love for the parent Society will not be lessened by the fostering care you may devote to its offspring. The above, to my mind, is the special feature to be considered the coming year. I also hope that during the coming year the Committee on Program will succeed in inducing more of our non-resident members to take a place on our program, and also that our Committee on Growth and Prosperity will succeed in bringing more non-resident members into the Society and interesting them in its work, for I believe it will not only benefit us all individually, but it will add materially in directing the attention of the profession of Northern Ohio toward Cleveland as a medical center. Besides our very interesting quarterly meetings, which we hope to continue, I hope we will be able to secure occasionally a wellknown man from some adjoining city in Ohio to be with us, and open the discussion on some paper to be presented. The profession all over the State of Ohio has had its attention especially attracted to this Society, not only by reason of its rapid growth and scientific work, but also by the men of international reputation who have come from some of the medical centers of the East under the auspices of this Society, to read papers and hold clinics before the profession of this city. Among the live and very interesting questions of the day, especially to our profession, is that of medical legislation, and I want to see, not only this Society, but every Medical Society in the State a unit in their efforts to secure the passage of some suitable "State Medical Bill," to the end that Ohio in the near future may not be, as in the past, a dumping ground for quacks and charlatans. And in this connection I am glad to see that a member of our own fraternity, and one clearly in sympathy with this

movement for a State bill, has been made Chairman of the Committee on 'Medical Colleges and Medical Societies,' before whom will come any proposed medical legislation.

In connection with our fortnightly meetings, and that we may offer more of an inducement to our non-resident members, I would suggest that a committee of three be appointed to have charge of arranging with the different colleges and the individual clinical teachers of our city, and to have posted upon a suitable bulletin board in our meeting room a detailed program of the clinical operative work to be done at the different hospitals the ensuing day or morning. In this way, I believe, there will be attracted to our city and our meetings many physicians from surrounding towns who would perhaps not otherwise come, and this is one of the means of making Cleveland an attractive medical center. Another thing: Encourage outside or non-resident members to bring their more important clinical cases before the Society for examination and discussion. Let it be known that for medical and surgical advice, and thorough facilities for medical teaching Cleveland stands among the first cities of the West. We can make these meetings so interesting and instructive that every regular physician within a radius of fifty miles of Cleveland will see and appreciate the necessity of becoming a part and parcel of this organization.

The present prospects and assurance of having an official JOURNAL that is in thorough sympathy with the aids and objects of our Society, leads me to suggest that as a Society, and as individual members, we ought to do all in our power, by our good will and support, to make this the leading JOURNAL of the State and the West. This JOURNAL gives all its exchanges to the Cleveland Medical Library, and for this alone is worthy of the support of every physician in the City of Cleveland.

I would suggest that this Society lend its influence and encouragement to the city's Health Officer and to the municipal government in their efforts to establish a bacteriologic laboratory. This is much needed in Cleveland, and it would be commendable for this Society to lend its influence in furthering such a project. I would also suggest that an effort on the part of this Society be directed toward securing the State meeting for Cleveland in 1897. And to this end I hope that a goodly number of members will find it convenient to go to Columbus the coming May, when the question of a meeting for '97 will be settled.

That this Society may keep pace in growth and influence with "Greater Cleveland," and considering the very rapid strides she has made thus far, it seems to me it might be wise and proper to consider, at this time, the advisability of securing a building of our own, or at least a part of a building which shall be devoted to the Medical Library and this Society's work, a building with our meeting-room adjoining the library, with a nurses' directory, a bulletin of clinics to be held at the different hospitals, and a bureau of general information, so-called, where visiting physicians can obtain any information in regard to our hospitals and the medical institutions of the city. This may be considered visionary but the time is coming, is perhaps not far distant, when this question will be discussed, and it is but natural that this Society should take the initiatory step; and while it may be that the full realization of this hope may be away in the future, I believe it is proper that a foundation should be commenced by the appointing of a special committee. I therefore suggest that a committee be ap-

pointed, consisting of three members, whose duty it shall be to consider the practicability of raising funds for buying or renting a suitable building, or part of a building, that shall be devoted to the Cleveland Medical Library and the Cleveland Medical Society's work, this committee to have power to confer with the building committee of the Chamber of Commerce, with a view to securing suitable rooms in their new building when completed, if this seems advisable. And finally let us do all we can to unify the profession of Northern Ohio. Make Cleveland the medical center of Ohio by doing more and better scientific work, inducing members to prepare, if possible, more carefully their papers and discussions. And I believe that the publication of our transactions will stimulate the members to do this. Our great hope is that all the medical institutions of our city, the hospitals, medical colleges, and all the societies may work in harmony to place Cleveland where she justly belongs, in the front rank among the medical centers of the United States. And I sincerely hope that our Society may continue to be, in an increasing degree, the great instrument working for harmony and scientific attainment, and that each succeeding year may be more prosperous and successful than its predecessor.

On motion of Dr. Wirt, the President appointed as a committee to consider the suggestions of the President's address, Drs. Wirt, Rosenwasser, Tuckerman, Hoover and Humiston.

DR. WIRT: I would also offer a resolution covering a point brought up this evening:

*Resolved:* That the Constitution and By-laws of the Cleveland Medical Society be so amended as to permit the formation of sections.

DR. HUMISTON: I move you that the thanks of this Society be tendered to the Banquet Committee for the delightful banquet they gave us two weeks ago tonight, and also to Mrs. T. M. Sabin and Mrs. Harold T. Clapp. Carried.

### Report of Cases and Exhibition of Specimens

DR. N. S. SCOTT

#### *A Case of Fractured Patella*

I have a case here that I desire to show the society, a case of fracture of the patella, which presents some features of special interest. You all know how difficult it is to apply a dressing to the patella on account of the inability of fixing the upper fragment. This man was brought into the hospital last September. A glance at the man's face showed that he was very white. That was the first thing that struck me. His utterance was very incoherent showing that his mental condition was poor. On account of his waxy appearance we made an examination of the urine and found albumin. Examination of the heart showed it dilated and irregular, and an intermittent pulse. Any operative interference then was contraindicated. We made out a stellate fracture of the patella. No bandage could be applied that would do any good. I made use of a little device. His whiteness is not anything compared with what it was when he entered the hospital. The man was found on the railroad track. He has no remembrance of how he came to the hospital, or anything happening in the next ten days. His utterance at the time was very incoherent; he was able to answer questions but evidently without knowing what he was saying. This ring was applied in this way. There was no difficulty in replacing the

fragments. They were replaced in position and this ring placed upon them and firmly bandaged. The man has made a most excellent recovery under this simple plan.

### Discussion

DR. WIRT: We have had an exhibition of his walking but with the cast on I think it is hardly a fair demonstration; because with fracture of the patella the main difficulty is in throwing the foot forward, the muscles not acting on the tibia. With the cast on of course that would make it possible. And, therefore, I would like to ask how much of a cast he has on, and how he walks without the cast. Of course with the cast, even if it were completely fractured, he could walk fairly well.

DR. SCOTT: I have not seen him very lately. Union in this case was very slow, occupying about three months' time in all. I know that he has not a bony union; it is fibrous; and I realize that this fibrous union will gradually retract. It was the best we could do under the circumstances. I have not seen him without the cast, and I do not know how he can walk.

DR. CORLETT

### *A Case of Syphilis*

We have here a case that is not presented on account of its rarity, because probably many gentlemen here have had an opportunity of seeing cases similar to this one, but it is presented on account of its diagnostic value. We have certain tell-tale scars on the forearms as well as on the legs. On the forearm near the wrist is a perfect horse-shoe scar which I consider characteristic. The main lesion here over the deltoid, active, red and worm-eaten is also characteristic. It might be mistaken for *lupus vulgaris*; it might possibly be mistaken for a malignant growth, but we can demonstrate from the history of the case that it is neither of these affections. I do not obtain it from the patient because I do not often rely upon the patient for a history. I supply the history myself.

About fifteen years ago, according to the history I gave the class, the patient had an initial lesion of syphilis. This was followed by enlargement of lymphatic glands, falling of the hair, which returned, a sore throat and slight evanescent rash. Since then he has had sores of various shapes and sizes, has gone to the doctor, taken medicine and has got well, but the disease has broken out again.

The patient disagrees with me in regard to the entire history, and says the initial lesion appeared eight years ago instead of fifteen, showing that the disease has pursued a very rapid course and is what might be called malignant syphilis.

DR. WOODWARD

### *Case of Fracture of the Femur—Treatment*

I have a case to present, but it will take me more than five minutes as I am going to make a demonstration of the dressing.

One of the patients went out of the hospital yesterday. I saw him this morning and he promised faithfully to be here; but as he loves his doctor less than he does whisky I presume he is on what would be called in a police court a "plain drunk," and I have to beg your pardon. The case which I have to present is not nearly so good a result, and is not so good an example. I wish in the first place to disclaim any originality. This is not my box. I have employed it considerably; but the dressing is originally that of Dr. Young, an old surgeon of Cincinnati, who was at one time a

staff officer of mine. The dressing is not known here, and as it is the best box for fractured thigh I think it should be presented to the profession.

The inner box slides on the outer box without any friction whatever. These rolls are set into the bottom without coming through. The bottom of the box is plain, and in that way the bedclothes do not impinge on the rolls. The leg is suspended in the inner box. The outer box is beveled to the distance of 18 inches so that there is no bare edge for the patient's hip to lie upon. The outer board is long and comes up to support the hip on the outside. The board coming up against the perineum is the keynote of the box. In making any application to the thigh the object is to extend and counter-extend that limb. Ever since the earliest history this has been the object to attain, to prevent the over-riding of the bones. In a splint like the Volkmann, I maintain that no matter what weight you may put upon it, it does not extend the limb. You get the immobilized lower fragment, and you have to depend upon counter-extension. This in the Volkmann is attained by raising the foot of the bed. If it were possible to suspend the patient by the heels you might get the entire weight of the body for counter-extension. I will have an orderly from the hospital placed in the box so that you may see how it is arranged.

In this dressing the weight pulls on the leg; it does not pull on the body. No one likes to have his leg pulled, but when the patient slips down in bed, on account of this perineal board the weight keeps on pulling. In this case the counter-extension is not made by lifting up the foot of the bed but is compulsory by reason of the construction of the box. There is never at any time any sudden, quick jar. The beveling of the board permits the passage under the patient of the bed-pan, which is done with great facility.

The proof of the efficiency of any dressing depends on the results of the dressing. The man I intended to show you was a sailor. When he was admitted to the hospital we anesthetized him, examined him and found the thigh-bone was broken at the junction of the lower and middle thirds, and the middle and upper thirds; there was a fracture of the internal malleolus of the opposite ankle. We put him up in this dressing and left him for six weeks. At the end of six weeks I took him out of the dressing. Dr. Allen measured the limbs and found the fractured limb was one-fourth inch longer than the good one. We put him up again for two weeks. At that time we took him down and put him on crutches. In three days he took a hobbling step. He went out yesterday from the hospital to go to work.

The man that we have here fell a distance supposed to have been fifty feet. He came in having a fracture of the thigh just below the trochanter, like the specimen shown by Dr. Crile a short time ago.

This case was put into the box and left for six weeks as before, and again my distinguished friend Dr. Allen examined the limb, and found that there was one-eighth inch shortening. We let the men get up and they have been up ever since, and in each case there has been one-quarter inch shortening as a final result. In other words it brought the limbs of the man who is not here tonight to exactly the same length. In this case the injured limb is one-eighth shorter.

To illustrate how that compares with normal men, we examined in the hospital under the same circumstances sixteen men who had never had any injured limbs. Out of the sixteen that we examined there were four normal limbs worse than this patient here; and of the others there were only three with perfect limbs.

## Discussion

DR. WENNER: I had the pleasure of seeing the first case Dr. Woodward refers to, and I can testify that the man's leg was longer than it really ought to have been.

DR. WIRT: I have examined this box and am very much pleased with it. I have a word to say in regard to the amount of shortening you get in these cases. On that subject I would say that at a meeting of the American Surgical Association at Washington, a few years ago, a committee was appointed to bring in a report in regard to what shortening a limb might have and still be satisfactory, because it is something that comes up in litigation. This committee brought in a report and it was passed by the American Medical Association as its opinion, thus giving it good backing, that one inch shortening should be considered satisfactory. And one reason given why this should be received as a satisfactory result was that in many cases it was found that the normal limb is as much as one inch short.

DR. TUCKERMAN: I am very much pleased with the dressing. One thing I like is the support of the leg in the bandages in that way.

DR. SMITH: Old Dr. Young lectured at the Cincinnati Hospital when I attended lectures there, and it was said that he did more for the comfort of his patients than any other man, and his patients recognized the fact. He was constantly around with a shingle and a pocket-knife, trying to bolster up here and there. I was glad when the doctor said this was one of Dr. Young's boxes because all the students in Cincinnati tried to learn his methods.

## DR. HAMANN

*Intestinal Diverticula*

I have here three preparations which illustrate three forms of intestinal diverticula. The first is one of Meckel's diverticulum. These other diverticula are of some interest, although we do not know how they originate. They are the so-called false or pseudo-diverticula. You will note that they are on the mesenteric side of the gut. They are quite numerous. In Sir Astley Cooper's work on hernia they are mentioned. They consist of the peritoneum and possibly the mucous membrane. The other specimen is one I owe to the courtesy of Dr. Howard. It is what is called a traction diverticulum.

DR. TUCKERMAN: In a *postmortem* made about a year ago we found one of these Meckel's diverticula; in that case the apex was sharply pointed and there was a little string running from the end of it. In that case there was also quite a large concretion in the appendix, with no evidence of there ever having been any irritation from it.

DR. OHLMACHER: I have a case to report that is not of scientific interest; it is a case of misrepresentation. I want to say to the members of this Society that the circular which is passing among physicians from the Buffalo Antitoxic Co., purporting to contain a recommendation by me of its antitoxin, is entirely without authority. I made an examination of the antitoxin at the request of a representative of the company, but the test was not satisfactory because the toxins I used were found to be without virus. I simply want to go on record as offsetting this misrepresentation.



## Program

## DISCUSSION OF PAPER

*Pelvimetry, Its Importance in Obstetrics*

Read by DR. F. S. CLARK, December 27th, 1895

DR. ROSENWASSER: Pelvimetry is neither a new method nor is it a new problem. I have an old Baudelocque in which there is a cut of a pair of calipers, showing that pelvimetry was used over one hundred years ago. It is true, perhaps, that in this Country it has not been used as extensively as on the continent, particularly in the large obstetric institutions. We have not had any of these institutions until recently in this country. When I was at Prague in 1864 to 1868, it was as much a routine practice to use the pelvimeter as it is now; and while it is a method of precision of some importance, it need not be used as extensively in private practice as in large hospitals.

Most obstetric practitioners can make out approximately the size of the cavity of the pelvis without using the calipers. The index finger is the best pelvimeter. That is the best method of measuring the size of the pelvis, so far as the obstetrician is concerned. And then again, it is not entirely a matter of size of pelvis, but a matter of the relative size of head and pelvis.

The essayist assumes that the conditions in this country have changed, so that now we meet with many more contracted pelves than formerly. I doubt that very much. I believe the conditions have remained the same, but the teaching of obstetrics has been much improved. There were poor facilities for teaching that branch in our schools. For this reason these measurements were not made, but now that they are being made it has been found that they correspond pretty nearly with the measurements made in Europe.

In the hospitals of Europe these measurements are made as much a matter of routine as the taking of the pulse, looking at the tongue, or taking the temperature.

DR. SKERL: If, as the doctor said, we knew the size of head of various children, we then would have pelvimetry down to a scientific basis. But we cannot make a definite distinction. We do not know whether that head is going to be very soft and pass through the pelvis easily or not. In this country we are simply on the threshold, and if we can examine and measure every pelvis we come in contact with, and observe the method of labor, and what method of labor proves successful and what unsuccessful—by constantly doing this and by constantly recording our experience, we will have some idea of the treatment to be adopted in these minor deformities. I am glad the doctor brought the subject up.

DR. WOOLDRIDGE: I want to call attention to one thing. It seems to me very probable that there has been a change of condition among people in this country without regard to race. The point that occurs to my mind is that there was a very small percentage relatively who were dwellers in cities in former times. The percentage has been continually increasing, and it seems to me that in the nature of things we ought to expect a change of pelvis and other bony changes corresponding to that change of life.

DR. CLARK: I wish to thank the gentlemen for their interest in the paper. The importance of pelvimetry cannot be overestimated.

In reply to Dr. Rosenwasser, I wish to say that it was not my intention

to claim that pelvimetry is a new method to be used in the management of obstetric cases, for history proves that it is not.

In America its use is new, for, except in large hospitals and in the practice of the specialist, the pelvimeter is not known. Scarcely any of the general practitioners who do the bulk of the obstetric work ever owned a pelvimeter. While, too, the known percent. of deformities has been small, perhaps because pelves have not been measured, I do believe that conditions have changed for the reasons given, and that if comparison of measurements of the past and present could be made, such would be seen to be the case.

I would not make the internal measurement first. It is more objectionable to the patient. The external measurements will not be objected to, and if they are normal we need not make the internal. If less than normal on explaining such a fact the patient will not object.

I will only take time now to refer to one other point. Dr. Skeel says that for minor contractions of the pelvis it will be sufficient to wait for abnormalities in the mechanism of labor to disclose them. This will at once defeat the purpose and advantages of pelvimetry. Nothing but measuring a pelvis will tell certainly whether it is only a slight or serious deformity. It is not necessary to argue to show what delay might lead to. Then, too, it is often the lesser deformities that cause the serious injuries to mother and child. These injuries can be prevented only by knowing before labor is too far advanced that such deformities exist. After the head has become engaged, even slightly, the true conjugate can not be taken. The attendant can not then know what is causing the delay, and continuous pressure, followed by too late applying of the forceps, has been shown to be too often fatal to mother and child. This is but one example of the dangers of such a procedure as the doctor advocates.

I can only say in addition that only by an early examination of all pelves can we hope to obtain better results in our obstetric work. This we owe to our patients.

DR. G. W. CRILE

exhibited a very interesting series of stereopticon views illustrating some injuries to bones.

On motion of Dr. Ohlmacher the Society extended a vote of thanks to Dr. Crile.

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### Official Proceedings of the Union Medical Association of Northeastern Ohio

Ninety-eighth quarterly meeting at Akron, Tuesday, February 11th, 1896.

DR. L. S. EBRIGHT in the chair.

DRS. J. ROSS JAMESON of Apple Creek, H. A. MYER of Canton, S. H. STURGEON of Akron, were elected to membership.

The following officers were elected for the ensuing year: President, DR. HENRY S. UPSON of Cleveland; 1st Vice-President, DR. JAMES FRAUNFELTER of Canton; 2d Vice-President, DR. C. W. MILLIKIN of Akron; Recording Secretary, DR. L. E. SISLER of Clinton; Corresponding Secretary, DR. ALBERT HOOVER of Akron; Treasurer, DR. ELI CONN of Akron.

DR. MINER

*Physical Culture for Girls*

The paper appears in full in this number of the JOURNAL.

DR. T. C. MILLER said that he considered the paper an important one. The author does not mention differences in the anatomy of males and females. The greatest difference is that from 11 years of age the girl has to develop into a woman. This kind of development is a different one from that which boys undergo. The woman must develop a pelvis for the bearing of children. The development of the uterus and ovaries gives shape to the pelvis. If the girl does too much work the pelvis may develop into the male type. I doubt if the girl will bear the exercise that a man will. Educated women are comparatively sterile. The fact is that the uterus is small and incapable of bearing children, because it has had no chance to develop during the time of study. Such a uterus is as incapable of bearing children as yours is, Mr. President.

DR. WIRT: Exercise for girls, is, we will all agree, good for girls; for the heart, viscera, liver and skin. I don't think that the idea that exercise prevents development of the uterus agrees with the fact that Indian women and women of the lower classes, who undergo severe physical labor, bear better than do the higher classes. Exercise develops the uterus as well as other organs. Nine-tenths of all cases of scoliosis of the spine are found in girls, probably because girls exercise less than boys. While the boys play out-doors at leap-frog and ball, girls are playing with dolls and at other games in-doors. If the muscles and ligaments of the spine are not developed the spine deviates from the straight line. Exercise, corsets and shoes, well-adapted to the purpose of straightening the spine, give in these cases a great improvement within a month from the beginning of their use.

DR. MINER, in closing the discussion said: We have to take girls as we find them. As a matter of fact, our girls are kept in school and are not given exercise. This is the time to give them proper development. I do not advocate foot-ball for girls, but exercise to properly build them into perfect womanhood. A case in our town occurs to me of a girl who went to Vassar weak and sickly; she came back the best developed girl in her class. That is the kind of physical culture we want.

DR. T. CLARKE MILLER

of Massillon, gave an interesting lecture on

*Puerperal Convulsions*

He had tried various remedies for eclampsia and found large doses of opium the best method of treatment. He warmly advocates its use in properly selected cases.

DR. LEONARD said that he does not push morphin narcosis as far as does Dr. Miller. By giving bromid and chloral after morphin, he does not have to give another injection so soon. It is from 15 to 20 minutes before you get the effect from a hypodermic; then begin elimination at once through the skin and bowels.

DR. SPENCER's experience did not warrant the use of morphin to such an extreme degree. He uses many of the remedies mentioned, particularly bromid, chloral and veratrum, and has had very good success.

DR. FRAUNFELTER was not willing to push morphin to quite such an extent. He had good results from veratrum viride. If he used morphin he would use calomel with it to act on the bowels and kidneys.

DR. HUMISTON said that in Dr. Miller's hands morphin in such large doses might be safe, but he hardly thought the method generally applicable. His methods consisted in the hypodermic early and bromid and chloral by the rectum. Then he puts his patient into a hot bath and gives a hypodermic of pilocarpin. The patient comes out of the bath and sweats for six hours. As soon as consciousness is regained he gives ten grains of calomel and gets elimination through the bowels, kidneys and skin.

DR. REED at first fought convulsions with pilocarpin, bleeding and chloral, with very little success. Of late years he has seen several cases in conjunction with Dr. Miller; he has used morphin and has not lost a case.

DR. MILLER in closing said that there was some justice in what Dr. Leonard says in regard to heavy doses of morphin. It is necessary to watch the breathing, and it sometimes answers to bring respiration down to eight per minute. I have brought them as low as from three to five per minute. Sometimes in cases where respirations came back to eight per minute, convulsions reappeared, and then they must be brought again under seven. In the last case I brought them down to three a minute and the bronchial tubes filled with mucus. After some hours the breathing was four per minute and the circulation improved. Finally she breathed seven per minute and began to twitch. I then gave her morphin by the mouth. The breathing was reduced and the twitching ceased. The patient made a good recovery. I try to impress it on every man that a respiration of three is dangerous, but you must remember that we are fighting a dangerous disease.

DR. C. B. PARKER

*The Diagnosis, Prognosis and Operative Treatment of Tumors  
of the Breast*

The address was listened to closely throughout and was a thorough treatment of the subject.

DR. EBRIGHT

*The Use of Antitoxin in Diphtheria*

This paper appears in full in this number of the JOURNAL.

The incoming PRESIDENT appointed the following committees:

Admissions, DR. T. CLARKE MILLER, DR. C. W. MILLIKIN, DR. C. B. PARKER.

Publication, DR. E. P. MORROW, DR. D. S. BOWMAN, DR. W. H. HUMISTON.

Finance, DR. L. S. EBRIGHT, DR. N. S. EVERHARD, DR. G. L. STARR.

Ethics, DR. J. B. CLEAVER, DR. M. M. BAUER, DR. F. B. MINER.

Obituaries, DR. A. M. SHERMAN, DR. W. W. LEONARD, DR. N. STONE SCOTT.

The following program was announced for the next meeting to be held at Canton, May 11th: Essay, DR. J. H. SEILER, DR. H. BLANKERHORN; Lecture, DR. SAMUEL WRIGHT, DR. A. E. FOLTZ; Discussion, DR. F. FRAUNFELTER and DR. WIRT; Reports of Cases, DRs. LEONARD, STRAIGHT, SPENCER, WALKER, JACKSON and BAUER.

## Medical News

**Dr. Herman Bauer** is about to leave the city.

**Dr. J. P. Sawyer** is making a short trip in the south.

**Dr. T. R. Stack** spent the first week in February visiting in Wisconsin.

**Dr. H. M. Page**, of Hiram, visited friends in this city February 10th.

**Dr. E. F. Cushing** has gone to Bermuda on a short trip for the benefit of his health.

**Dr. C. A. Hamann** recently made a trip to Columbus and Cincinnati, visiting the medical colleges in both cities.

A so-called medical journal of Kansas City publishes regularly the "ad" of a "cancer-cure" (with portrait of the curer.)

**Dr. Morris J. Lewis**, a well-known physician of Philadelphia has been elected a trustee of the University of Pennsylvania.

**Dr. B. L. Milliken** is spending a few weeks in Florida; he has wisely chosen the blizzard month of February for his trip.

**The Minneapolis College** of Physicians and Surgeons has become the Medical Department of Hamline University.

**Dr. Eliza Mosher** of Brooklyn has been made Professor of Hygiene in the University of Michigan, Ann Arbor, and Dean of the Literary department.—*Medical Record*.

**Dr. John P. Gruwell** of Alliance, said to be the oldest graduate of the medical department of the University of Pennsylvania, died January 20th, aged 86 years.

**Dr. John E. Woodbridge**, of Youngstown, has removed to this city, and taken the Pierce house on Prospect street, where he will reside and also have his office.

**Dr. J. R. Gonell**, of Newton, Iowa, we learn from the *Iowa Medical Journal*, has just published a romance of love, war and religion, entitled "Sins Absolved."

**Dr. Frank E. Bunts** leaves early in March for an extended trip to Europe. He expects to be absent most of the summer and to spend a large part of the time in work.

**Dr. J. G. Meacham, Sr.**, President of the Wisconsin State Medical Association, and a man widely known in American medical affairs, died at his home in Racine, Wis., on February 1st, of heart failure.

**Psychological Twist.** Dr. T. Lauder Brunton has made a psychological analysis of President Cleveland's message on the Venezeulan question, and concludes that it is really a powerful plea for peace.—*Medical Record*.

**Dr. Daniel Lewis** has retired from the editorial management of the *American Medical Review*. This is much to be regretted, but it is hoped that the change will not interfere at all with the success of the *Review*.

**Dr. Henry W. Kitchen** has just returned from Mexico and reports having had a very enjoyable time.

**The Medical Record** announces that Dr. George Dock, of Ann Arbor has declined the chair of pathology and bacteriology in Jefferson Medical College, to which he was recently elected.

**The Medical Herald** announces that the diplomas of the College of Physicians and Surgeons, at Keokuk, Iowa, and the Northwestern Medical College of St. Joseph, Mo., have been refused recognition by the respective State Boards of Health.

**The widow** of Dr. D. Hayes Agnew, the eminent Philadelphia surgeon, has recently died. Her death renders at once available a legacy of \$50,000 to the University of Pennsylvania Medical Department which, by terms of Dr. Agnew's will, was subject to a life interest of his widow.

"**The use** of writing is to represent the sound of the words, not to be everlastingly harping upon the Greek and Latin forms. But few people can see this, and when a thing is wrong they stick to it all the same."—Prof. W. W. Skeat, London *Lancet*, January 4th, 1896.

**Dr. C. A. Hamann**, Professor of Anatomy in the medical department of the Western Reserve University, Cleveland, Ohio, attended the clinic of the Ohio Medical University on the 23d ult., and in addition visited a number of the profession in the Capital City.—*Columbus Medical Journal*.

**The Committee** of Arrangements of the Ohio State Medical Society, composed of Dr. J. F. Baldwin, chairman, Drs. E. B. Fullerton, C. O. Probst, S. S. Wilcox and R. Harvey Reed, held its first meeting at Dr. Baldwin's office on February 4th.—*Columbus Medical Journal*.

**The Medical Profession** of this city will regret to learn that Dr. Horatio C. Wood, according to the *Medical News*, had a bad fall from his bicycle on January 16th, resulting in a slight concussion of the brain and two severe scalp wounds. He has gone South for rest and recreation.

**The Philadelphia County Medical Society** has a membership of over 700. At its recent annual meeting, when the election of officers for 1896 was held, and when certain large expenditures were authorized, 32 members were recorded as voting.

**The Maryland Medical Journal** announces that the chair of Pathology in the University of Michigan has been abolished. The occupant of this chair, we are told, was "imported" a few years since. The work is to be distributed among other chairs.

**Kenneth N. Fenwick**, M. A., M. D., M. R. C. S., Eng., a prominent Canadian physician, died at his home in Kingston, Ont., January 21st, at the age of 44. His death was due to septicemia acquired five days before his death by cutting his finger while operating upon a child for septic peritonitis. Dr. Fenwick was an unusually fine man and his death is a great loss.

**Dr. Bernstein** will shortly complete his term of service at the City Hospital. Dr. A. Hoover will succeed him as house physician. A new resident will be elected by the staff in May.

**The diphtheria** death-rate of Paris, which has been below 10% for 18 months, rose to 23% and 17% for the first two weeks of 1896. This too in spite of the fact that there were fewer cases of the disease.—*La Médecine Moderne*, January 15th, 1896.

**Our western** contemporaries announce that three medical colleges of Kansas City have refused to comply with the requirements of the Missouri State Board of Health. This means that their diplomas will not be recognized by their own State.

**Dr. B. O. Coates**, who was recently compelled to undergo the operation for appendicitis has been making an extended visit among friends and relatives in Toronto, Ont.

**The Buffalo Academy of Medicine** has profited by the example of the Cleveland Medical Society and upon January 21st, listened to a lecture upon "Principles of Preventive Inoculation and Serum Therapeutics" by Dr. A. C. Abbott, Philadelphia, first assistant in the Laboratory of Hygiene in the University of Pennsylvania.

**Dr. John S. Dickson**, of Ashtabula, attended the January 24th meeting of the Cleveland Medical Society. Unfortunately the pleasure of his trip was marred by the fact that he had brought his wife here to be operated upon for ectopic pregnancy. We are sorry indeed to note that Mrs. Dickson died on February 2d.

**Danger**—Evidently a diploma-mill has been opened in Chicago. Their graduates will not meet with much favor with the State Board of Health. From the *Des Moines Register* we clip the following ad: "How to become lawful physicians; course by mail. Illinois Health University, Chicago."—*Iowa Medical Journal*.

**That Philadelphia Medicine** does not occupy a high position in the esteem of the American profession is due to the simple fact that the profession does not know what is being done here. It may be added that the local profession itself does not know what is going on within its own territories. Of this more hereafter.—*Medical and Surgical Reporter*.

**The medical profession** should feel grateful to the *Ladies' Home Journal* for having decided to decline all advertisements of a "medical, remedial or curative nature." This step was taken because the paper was unwilling to assume the implied responsibility of carrying such advertisements. There are no signs that the so-called religious papers, which are the richest field for the patent-medicine man and the quack, are contemplating any similar step.

Several of our exchanges are belittling themselves and the medical profession by publishing straight patent medicine ads. which are written for the public eye especially, and not for the profession. The most ubiquitous of these, perhaps, is "One Gives Relief," and the other is a patent Impotence and Stricture Cure. It is nothing short of a disgrace that medical journals should descend to so low a depth of ignominy and insult the profession by inserting such advertisements.

**Dr. T. A. Hopkins**, Associate Editor of the *Medical Fortnightly*, of St. Louis, favored the JOURNAL with a friendly call February 10th. Dr. Hopkins hailed originally from Ashtabula County, and is also a graduate of Oberlin College, so that his visit was welcomed by a large circle of friends. The doctor is interested in genitourinary surgery, and is connected with the College of Physicians and Surgeons of St. Louis. The doctors visit was much enjoyed by the JOURNAL, and its best wishes go with him.

**Dr. Jameson** is a Scotchman by birth, and was educated at University College, London. He became a member of the Royal College of Surgeons in 1875, Bachelor of Medicine and Surgery of London University in the same year, and graduated as doctor in 1877. Shortly after he went to Kimberley, where for many years he was a leading physician. He then formed the friendship of Mr. Cecil Rhodes, who came to him as a patient. He has been created a Companion of the Bath and is the administrator for the British South Africa Company.—*Medical Record*.

The following card advertisement appeared in the *Cleveland Leader* of recent date: "I wish to publicly tender my thanks to Dr.—, — Ave., for successfully treating my two children, Annie and Louis, aged respectively 14 years and 13 months, the former having been dangerously ill with diphtheria and the latter with membrane croup. I wish to recommend the doctor to all who may need his services. —, — St." This is a novel and unique form of advertising, and deserves to be brought widely to the attention of the profession as promising to be of very great utility.

**Prof. George A. Coe**, Professor of Philosophy in the Northwestern University, in an address before the Doctor's Club, of Chicago, on "The Ethics of the Free Dispensary," asserts that four particular, if not distinct, interests are involved.

- 1st.—The interest of the poor.
- 2nd.—The interest of the physician who gives his services.
- 3rd.—The interest of the physician whose income may be reduced through competition with the free dispensary.
- 4th.—The interest of medical science and education; and the true solution of the question lies in the harmonizing of these interests.—*Bulletin American Academy of Medicine*.



**A new City Laboratory** has been established in Boise, Idaho, Surgeon Wood, U. S. A., of the Boise barracks being in charge. The building is the joint donation of the city and of some of the earnest bacteriologists of the place.—*Medical Record*. This put Cleveland to shame.

In his annual report President Seth Low, of Columbia, says: "I conceive therefore, that it should be Columbia's policy, slowly, if you please, but steadily, to raise the requirements for admission to all her professional schools, until a liberal training, equivalent to the old-time college course, is demanded as a condition for admission to every one of them." He hopes that Columbia may soon announce such a rule. He qualifies it by pointing out the necessity of reform in the college course as at present organized. Men must get their bachelor's degree at a younger age—for instance their college course may extend over the ages of sixteen to twenty.

**A Western contemporary** noted rather for the quantity of its circulation than for the quality of its reading matter, is waging bitter and uncompromising warfare against antitoxin. No one disputes its right to a definite opinion upon this or any other matter, but its crusade is too relentless and its language too intemperate to pass for the calm scientific discussion to which it pretends. Its attitude is that world-old one of ignorance and prejudice opposing progress. The antitoxin may not be all that is claimed, it is very likely, but the attitude of our contemporary towards it, would, if it became general, block all therapeutic progress. Even the possible correctness of a measure of its views, which we do not admit, would not justify any journal in being so bitterly one-sided in all the information it prints concerning antitoxin. In fine we hear in our contemporary the voice of a physician a generation behind his profession, who is unwilling to see even a grain of truth in modern progress.

**Medical Journalism** has been quite upset by the removal of the *Medical News* to New York. The *Lancet-Clinic* has taken it particularly hard and devoted several editorials to proving that it was due to non-support by the great drug-manufacturing houses in Philadelphia. The *Lancet-Clinic's* views certainly contain a large measure of truth. Dr. J. M. Baldy, however, writes that on the other hand the publishers of the *News* have squeezed out of the Philadelphia profession all the support to be had for that character of house and have been forced to seek new pastures. He says these publishers have had the best books of Philadelphia's production and have grown wealthy by paying the authors little or nothing for their work. The arrival of a liberal publisher upon the scene has materially interfered with their business and so they move. Dr. Baldy also plainly intimates that Philadelphia will very shortly have an independent high-class journal which will have powerful backing.

We are in receipt of the announcement of an insurance company which enters a somewhat new field—The Protectors' Indemnity Corporation of Pennsylvania. Mutual benefit societies have for a long time paid sick benefits to unfortunate members. This company proposes to take up this work and insure against sickness. The rates are low and it will be interesting to watch the result of the enterprise. Some few previous attempts of this character have been unsuccessful, but it would seem to be merely a matter of experience; when the average sick period of sound risks has been ascertained the success of the plan should not be doubtful.

On the preliminary program of the State Society for its meeting in May are the names of Dr. Dudley P. Allen and Dr. L. B. Tuckerman. A number more Cleveland physicians should appear upon the program when complete. The scientific medical work of Cleveland is the equal of that in any city in the State and it should be well represented at Columbus this year. An officer of the State Society writes: "There is an opportunity for Cleveland to bring herself right to the front in State Society matters this very year. Let us see Cleveland rival Cincinnati in numbers present and in medical oratory." The State Society must meet here in 1897.

Dr. C. G. Comegys, the well-known Cincinnati physician, died of influenza, February 10, in his eightieth year. He graduated from the Medical Department of the University of Pennsylvania in 1848 and at once settled in Cincinnati where he remained a model citizen for 48 years. From 1852 to 1868 he held various chairs in Cincinnati medical colleges. He was, as is well-known, an active member of local, state and national medical organizations. He was an active citizen of Cincinnati taking a foremost part in its municipal affairs, serving at different times as member of Common Council, School Board, and Board of Directors of Cincinnati University. His character may be shortly summed up by saying he was a great man. A called meeting of the Cincinnati Academy of Medicine was held February 11th and resolutions of regret at the death of Dr. Comegys were adopted. Cincinnati has lost one of her foremost citizens and the medical profession a sincere and persistent worker for the betterment of his profession.

### Some Remarkable Figures

Dr. N. R. Coleman, of Columbus, in his opening address upon the Kimmell Bill before the Committee on Medical Colleges and Societies, at the hearing on January 22d gave some statistics of the medical profession of Ohio which differ materially from previous data. 'There are,' he said, 'in Ohio about 9,000 physicians, of whom 6,814 are regular physicians, 1,999 are eclectic, 678 homeopathic, 156 physio-medical, and 757 unclassified.' Heretofore it has been always thought that the homeopaths were twice as strong as the eclectics, but these figures quite reverse the ratio.

**Index of foreign medical journals received during the past month by the Cleveland Medical Library Association, and now on file in the Case Library**

For Index of American Journals see the American Medical Review

*Lancet.*

- Jan. 4, '96—Fractures of the Lower Limb.—*C. Heath.*  
 History, Medical—Contribution to—Thomas Dover.—*Osler.*  
 Bronchocele Cystic, necessitating complete removal.—*Stokes.*  
 Eczema, peri oral, outbreak in the East End of London.—*Saull.*  
 Abdominal Operations—Group of 27.—*Treves.*  
 Word Blindness and Visual Memory.—*Broadbent.*  
 Albuminuria, some forms associated with Kidney Tension, and their treatment.—*Harrison.*  
 Cleft Palate—Operative Treat.—*Owen.*  
 Lymphadenoma, 2 cases. presenting unusual symptoms, with post-mortem exam.—*Mackenzie.*  
 Heart Disease, treated by Schott Method.—*Thorne.*  
 Jan. 11, '96—Isolation of Fever Patients.—*Cameron.*  
 Gleanings from Surgical Practice.—*Bryant.*  
 Surgery of the Kidney—Cases.—*Thorn-ton.*  
 Milk, Special, for Infants —*Cautley.*  
 Cancer of the Breast.—*Jennings.*  
 Jan. 18, '96—Heart in its Relation to Pregnancy, Parturition and the Puerperal State.—*Jones.*  
 Professional Unionism.—*Dickinson.*  
 Necessity of Med. Union.—*Sturges.*  
 Hemorrhages and Urticarias, which are associated with deficient blood coagulability.—*Wright.*  
 Varicose Aneurism of Ascending Aorta.—*Clark.*  
 Club Feet, Method of Examining.—*Tubby.*  
 Tetanus treated with Tetanus Antitoxin; notes in 2 cases.  
 Accidents of Lens Extraction.—*Taylor.*  
 Cocain Anesthesia — Observations.—*Clarke.*  
 Jan. 25—Dementia from poisoning by Carbon Monoxid.—*Scott.*  
 Quinin as Prophylactic in African Fevers —*Flinn.*  
 Caesarean Section, Case of.—*Row.*  
 Poisoning by Gas in Sewers.—*Holden.*

Transperitoneal Ligation of the Common Iliac Artery for Diffuse Traumatic Aneurism of Ext. Iliac and Common Femoral Arteries—Recovery.—*Stevenson.*

Pathology of Diphth.—*Trevelyan.*

Thoracic Aneurism, Case of.—*Underwood.*

Feb. 1, '96—Anesthesia, Nature of.—*Buxton.*

Anemia, Pernicious, with special reference to treatment with bone marrow.—*Hunt.*

Hemorrhage into great Omentum; Case of.—*Bush.*

Small Pox, Hemorrhagic— Recovery.—*Ricketts.*

Tetanus, Chronic, treated by Tizzoni's Antitoxin—Recovery.—*Tracey.*

Archotomy, Unilateral, for Enlargement of Prostate.—*Moullin.*

*British Med. Journal.*

Jan. 4, '96—Glenards Disease — Treatment by Abdom. section with some remarks on Intestinal Neuroses.—*F. Treves.*

Retention Cysts of Cowpers Glands as a cause of Chronic Gleet, etc.—*H. Fenwick.*

Anaerobes, Apparatus for Cultivation of.—*Hamilton.*

Pathology of Vaccinia and Variola.—*Copeman.*

Colpotomy, Anterior.—*Martin.*

Rickets, Recrudescence or Late.—*Caulley.*

Thyroid, Enlarged: Disappearance of Gland followed by Myxedema.—*Smith.*

Gunshot Wound; Case.—*Reid.*

Bullet Wound of Skull.—*McTodd.*

Gastrostomy Cases—After Treatment.—*Golding-Bird.*

Defibrinated Sheep's Blood for Transfusion.—*Baleman.*

Jan. 11—Rheumatism, Acute—*Cheadle,* with discussion.

Puerperal Fever in Private Practice.

Abdomen opening of from Vagina and Vaginal fixation of uterus.—*Taylor.*

Vaginal Celiotomy for tubal pregnancy.—*Dewald.*

Puerperal Fever, so-called — Surgical Treatment.—*Murphy.*

Jan. 18, '96—Mental and Nervous Element in Disease.—*Clouston.*

Lymphadenoma and its Relation to other Morbid Growths.—*Spencer.*

Ehrlich's Diazo-Reaction.—*Hewlett.*

Micro-Organisms—Fate of, in inspired air.—*Thomson & Hewlett.*

Haematogenous Jaundice, Experimental Evidence Concerning.—*Auld.*

Cancerous Development of Simple Ulcer of Stomach.—*Kelnyack.*

Formic aldehyd in Ophthalmic Practice.—*Davidson.*

Jan. 25, '96—Dermatology—Advantages to be derived from study of.—*MacKenzie.*

Diphtheria treated with Anti-toxin in Univ. College Hospital.—*Martin & Smith.*

Anatomical Treatise of the 14th Century—in an unpublished paper.—*Payne.*

Artificial Respiration—Certain grave defects in the System of—in chloroform asphyxia.

Thyroidectomy in lower animals.—*Murray.*

Diabetes Bronze.—*Hanot.*

Rheumatic Endocarditis—Arrest of.—*Calon.*

Bacillary Theory of Tuberculosis—Influence of—in the Treatment of Phthisis.—*Squire.*

Feb. 1, '96—Malarial Fevers—Benign and Pernicious.—*Manson.*

Malarial Parasites, Observation made in Secunderabad, Deccan.—*Ross.*

Diagnosis, Early, of Malig. Dis. of Uterus and Treat. by partial or total Excision.—*Knowsley.*

Diagnosis, Early, of Cancer of Uterus.—*Griffith.*

Bacteriological Examination of 1000 cases of suspected Diphtheria—Results.—*Hewlett & Nolan.*

Aseptic Wounds—Treatment, without Bandages or Dressings.—*Mackenzie.*

*Dublin Journal of Med. Science.*

Jan. '96—Colotomy and conditions requiring such operation.—*W. I. Wheeler*  
Ovarian Tumor—An interesting solid.—*A. J. Smith.*

Funis Presentation and Funis Prolapse with cases.—*E. J. Brady.*

Medicine and Surgery of the Homeric Poema.—*J. Knott.*

*Glasgow Med. Journal.*

Jan. '96—Amputation of the Scapula for Sarcoma, and preservation of useful limb.—*H. E. Clark.*

Landry's Paralysis.—*J. L. Stevens.*

Aprosexia, Convulsions and Adenitis dependent on Patholog. changes in the Paucial, Lingual and Pharyn. Tonsils.—*W. Downie.*

Etiology and Treatment of chronic enlargements of Lymphatic Glands, with special reference to those of the neck.—*J. H. Nicoll.*

*Edinburgh Med. Journal.*

Jan. '96—Valedictory address to Obstetrical Society of Edinburgh.—*A. H. Ireland Barbour.*

Teratogenesis: An inquiry into the causes of Monstrosities.—*J. W. Ballantyne.*

Typhoid Fever, case of, with unusual sequelae.—*J. C. Simpson.*

Gore of the abdomen by an Elephant's Tusk; case.—*T. K. MacDonald.*

Cellulitis, Extensive, with Necrosis of the Skin of the Abdomen in an Infant.—*Wm. Elder.*

Pathology of the Nervous System in Relation to Mental Diseases.—*W. F. Robertson.*

Oxaluria and the Excretion of Oxalic Acid in Urine.—*J. C. Dunlap.*

Feb. '96—Vaccination, Public, in Edinburgh.—*W. Husband.*

Surgical Measures in a series of Cerebral cases—Remarks on results.—*G. A. Gibson.*

Abortion, A Rare Form of, Haultain Mittelschmerz.—*J. H. Croom.*

Diabetes Mellitus in Early Infancy.—*Bell.*

Mental Affections and Allied Neuroses in Children.—*Ireland.*

Physiology of the Carbohydrates.—*Paton.*

*Berliner Klin. Wochenschr.*

Ueber Entzündliche, der Rückbildung fähige Vergrößerungen des Pankreas-kopfes.—*Rudel.*

Behandl. der Lebercirrhose; Harnstoff als Diuretikum.—*Klemperer.*

Künstliche Erzeugung von Knochengewebe.—*Barth.*

Colpotomia Anterior, etc.—*Wendeler.*

Jan. 13—Ileus, verursacht durch den persistirenden ductus omphalo-mesaraicus.—*Jordan.*

Cholesteatom des Schläfenbeins; Colpotomia Anterior, etc.—*Wendeler.*

Jan. 20—Ueber die Behandl. des Schmerzes.—*Goldscheider.*

Mechanismus der Gasgährungen im Magensaft.—*Bial.*

Localbehandlung der Larynxphthise.—*Kultner.*

Ein Unicum auf dem Gebiete der traumatischen Aneurysmen.—*Balza.*

Jan. 27—Günstige Dauerfolge durch ein verbessertes Operationsverfahren der Mammacarcinome.—*Rotter.*

Albuminurie nach Schutzpockenimpfung.—*Peiper & Schhaase.*

Behandl. des Schmerzes.—*Goldscheherd.*

#### *Deutsche Med. Wochenschr.*

Jan. 2, '96—Ueber die Affection des Herzens mit Tuberculose.—*Leyden.*

Ueber den Bau der Arterienwand.—*Bonnel.*

Pockenfälle im Krankenhaus Friedrichshain.—*Fürbringer.*

Bauchfelltuberculose. Operative Heilung.—*Israel.*

Trionalvergiftungen.—*Beyer.*

Behandl. der Inversio Uteri Mittels Kolpeurynters.—*Hohl.*

Jan. 9—Resection der Samenleiter als Heilmittel bei Prostatahypertrophie.—*Helferich.*

Ueber die Affection des Herzens mit Tuberculose.—*Leyden.*

Pockenfälle im Krankenhaus Friedrichshain.—*Fürbringer.*

Jan 9—Beitrag zur Lehre von der Albuminurie.—*Leick.*

Quantitative Salzsäurebestimmung im Magensaft von *Moracewski.*

Ueber ein neues Lösungsmittel der Harnfarbstoffe.—*Kramm.*

Motilitätsstörungen bei der hereditären Syphilis.—*Pollak.*

Jan. 16—Gesundheitschädlichkeit von Erdölrückständen.—*Dunbar.*

Pockenepidemie in Berlin.—*Vagedes.*

Hundert Fälle von Diptherie mit Behring's Heilserum behandelt.—*Adolph.*

Ueber ein neues Lösungsmittel der Harnfarbstoffe.—*Kramm.*

Jan. 23—Pustula Maligna, &c.—*Babes.* Endotheliome.—*Hausemann.*

Enteroptose und intra-abdominaler Druck.—*Schwerdt.*

Zur Behandl. der Atticuseiterungen, &c.—*Bruck.*

Primäres Sarkom der Pleura—*Blumenau*

Jan. 30—Die Roentgen'schen Experimente, &c.—*Jastrowitz.*

Temporäre Ligatur der grossen Gefässstämme.—*Riese.*

#### *Centralbl. f. Gynaekol.*

Jan. 4—Myoma Recti—ein Ovarial-Kystom Simulirend.—*F. Westermarck.*

Extrauteriner Schwangerschaft—Ein glücklich operirter Fall mit lebender Frucht.—*Adolf Reismann.*

18 Jan.—Salpiugo—Oophorectomia Duplex—3 Fälle von—bei Haematometra gynatretica—*M. Sanger.*

Zerreissung des Mastdarms bei abdominaler Adnexoperation.—*L. V. Dittel, Jr.*

Seccio Caesarea bei übermässig entwickelter, todtfauler Frucht.—*H. Ludwig.*

Eine neue Operation zur Beseitigung des Uterusvorfalles.—*A. V. Gubaroff.*

Jan 25—Symphyseotomiefrage—Kasuis-tischer Beitrag zur.—*G. Moyer.*

Webenthätigkeit des menschl. Uterus—Experiment, Untersuchung, &c.—*O. Schaeffer.*

Feb. 1—Scheide-Sarkom der, bei einer Erwachsenen—*W. Rubiska.*

Wehen—Pathologische in ihre Behandl.—*O. Schaeffer.*

Tubenschwangerschaft—Ein Fall interstitieller.—*O. Engstrom.*

*Arch. f. Gynaekologie*—50ter Band, 3tes Heft.

Cysten an der Tube, am Uterus und dessen Umgebung.—*Fabricius.*

Bakterien—Ueber die im weiblichen Genitalkanale vorkommenden—in ihrer Beziehung zur Endometritis.—*Gottschalk und Immerwahr.*

Beitrag zur Lehre des Coxalgischen Beckens und der Synostose des Ileosacralgelenkes.—*Peters.*

Zur kenntniss des Schwangerschafts und Geburtsverlaufes bei Antifixirten Uterus.—*Strassman.*

Tumoren—Bösartige der Chorionzotten.—*Apfelstedt in Aschoff.*

#### *Wiener Med. Wochenschr.*

Jan. 1, 1896—Albuminurie beim Abdominaltyphus.—*Zientz.*

Beitrag zur Klinisch-Bakteriolog. Studium der Influenza.—*Kamen.*

Jan. 4—Pseudodiastolische Mitralgeräusche, etc.—*Heitler.*

Albuminurie beim Abdominaltyphus.—*Zientz.*

Beitrag zum Klinisch-Bakteriolog. Studium der Influenza.—*Kamen.*

Jan. 11—Einleitung der vorzeitigen Geburt mittelst Iodoformgaze; Tamponade des Uterus.—*Frank.*

Aetiol. Prophylax. u. Therapie des Akuten Gelenkrheumatismus.—*Stekel*.

Jan. 18—Erfahrungen über Aethernarkosen.—*Rossa*.

Pilocarpinbehandl. der Pneumonia Crouposa.—*Sziklai*.

Einleitung der vorzeitigen Geburt mittelst Iodoformgaze; Tamponade des Uterus.—*Frank*.

*Centralbl. f. innere Medicin.*

Jan. 4—Lumbalpunktion—plötzliche Todesfälle nach—*Fürbringer*.

Quantitative Fibrinbestimmung.—*Kossler & Pfeiffer*.

Jan. 11—Beitrag zur Kenntniss der sogenannten physiolog. Albuminurie—*Zeheisen*.

Zur Behandl. der harnsäuren Diathese.—*Rosenfeld & Orgler*.

Jan. 18—Eiweisszerfall nach Schilddrüsennfütterung.—*Richter*.

Ueber den Einfluss des Salicylsäuren Natrons auf die Bildung u. Ausscheidung der Harnsäure.—*Bohland*.

Jan. 25—Untersuchung eines aus Borneo stammenden Pfeilgiftes—*Leubuscher*.  
Anaemia Splenica—zur Therapie der—*Köster*.

*Centralblatt f. Chir.*

Jan. 4—Zur Behandl. des Schlüsselbeinbruchs—*Braatz*.

Jan. 11—Castration bei Hypertrophie der Prostata.—*Roosing*.

Jan. 18—Ueber einen neuen aseptischen Verschluss von Wunden an Stelle der Wundnaht.—*Schürmayer*.

Jan. 25—Ureterimplantation in den Mastdarm.—*Krynski*.

Feb. 1—Methoden der Arthrektomie des Fusagelenkes.—*Lauenstein*.

*Arch. für Kinderheilkunde, 19ter Bd.—Heft V and VI.*

Galle, zur Chemie der Kindlichen—*A. Baginsky u. P. Sommerfeld*.

Spachstörungen in der Pubertätsentwicklung.—*Dr. H. Gatzmann*.

Casuistische Mittheilungen aus dem Jahresberichte der Kinderspitäls; Abtheilung der Allgemeinen Poliklinik in Wien—*von Emil Berggrün*.

Leukocytose bei Diphtherie.—*Von Dr. E. Schlesinger*.

*Neurolog. Centralblatt.*

Jan. 1—Stabkranz des menschlichen Grosshirns.—*Paul Flechsig*.

Secundäre Veränderungen der weissen Substanz des Rückenmarks bei Erkrankung der Cauda Equina.—*Darksheurisch*.

Beschäftigungs-Neuralgie.—Eine wenig bekannte Form der.—*M. Bernhardt*.

Jan. 15—Die Lehre von den Neurosen, &c.—*W. V. Bechterew*.

Zur Frage der Forensischen Beurtheilung sexueller Vergehen.—*Dr. A. Hoche*.

Ueber die Nervenzellen der gegen die Wuthkrankheit Eingepfosten Hunde.—*Bela Nagy*.

Feb. 1—Kritische Fragen der Nervenzellen Anatomie.—*Fr. Nissl*.

Die Lehre von den Neurosen.—*V. Bechterew*.

*Virchow's Arch. Bd. 143, Heft I.*

Ammoniak—Klinische u. Experiment. Untersuch. über die Bildung u. Ausscheidung von.—*Th. Rumpf*, in Hamburg.

Nasennebenhöhlen-Erkrankungen—Beiträge zur Pathol. u. Aetiologie.—*Eug. Fraenkel*.

Ueber den Durchtritt Corpusculärer Gebilde durch das Zwerchfell—*Dr. M. Sulze*.

Pancreas—Ueber das Bindegewebe des P. bei verschied. Krankh.—*M. Kasahara*.

Nerven-Beiträge zur Chirurgie u. Patholog. Anat. der peripherischen Nerven.—*Dr. Em. Finotti*.

Oesophagus Ueber mit Flimmer-Epithel ausgekleidete cysten des Oesoph-Pleura u. der Leber.—*Zahn*.

Perforation des S. Romanum in Folge eines Gestielten Darm.—

Sandkörper—Über die Struktur, das Vorkommen u. die Entstehung der S.—*von Semi Meyer*.

Naevuszellen—zur Epithelialen Abkunft der.—*von P. G. Unna*.

*Centralbl. f. prakt. Augenheilkunde.*

Jan. 1896—Accommodations-lähmung. 150 Fälle von postdiphtheritischer.—*Dr. Alf Moll*.

Magnet-Operation—Ein Beitrag zur.—*Julius Weisz*.

*Archiv. Generales de Medecine.*

Jan. '96.—Hernies Diaphragmatiques d'Origine Traumatique.—*Blum & Ambredanue*.

Diplégie Faciale Totale d'Origine Artérielle.—*Labadie-Levranc & Boix*.

Dilatations des Brouches.—*Duret*.

Somnolence et Narcolepsie Hepatiques.  
—*Levi*.

*Annales des Maladies des Organes Genito-Urinaires.*

Jan. '96.—Abouchement des Ureters sur l'Intestin — Recherches Experimentales.—*Boari*.

Stérilization des Sondes par l'Acide Sulfureux et par les Vapeurs de Formol.  
—*Janet*.

*La Semaine Medicale.*

Origine Hydrique du Cholera.—*Miler*—Jan. 1.

De l'Albuminurie Pretuberculeuse.—*Tessier*—Jan. 8.

Les Suppurations de l'Oreille et leur Traitement.—*Range*—Jan. 11.

Traitement de la Goutte Articulaire Aigue.—*Jacoma*—Jan. 15.

## Condensed Table of Mortality in Cleveland for January, 1896

*By courtesy of Dr. J. L. Hess, Health Officer*

### I—ZYMOTIC DISEASES

Measles .....	0
Scarlet Fever .....	0
Diphtheria .....	10
Croup .....	8
Whooping cough .....	1
Typhoid-fever .....	5
Cholera, cholera morbus and cholera infantum .....	4
Acute diarrhea .....	0
Chronic diarrhea .....	0
Dysentery .....	1
Cerebrospinal meningitis .....	3
Erysipelas .....	2
Malarial fever .....	1
Pyemia and septicemia .....	6
Alcoholism .....	0
Inanition .....	6

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### II—CONSTITUTIONAL DISEASES

Cancer .....	15
Rheumatism and gout .....	2
Marasmus, scrofula and <i>tubercles mesenterica</i> .....	6
Hydrocephalus and tubercular meningitis .....	1
<i>Phthisis pulmonalis</i> .....	44
Anemia .....	0

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### III—LOCAL DISEASES

Pneumonia and congestion of the lungs .....	31
Bronchitis, acute .....	6
Bronchitis, chronic .....	2
Tonsillitis .....	3
Pleurisy .....	0

Asthma .....	2
Congestion of brain and meninges .....	13
Apoplexy .....	4
Paralysis .....	7
Epilepsy .....	0
Tetanus .....	0
Convulsions .....	30
Other diseases of brain and cord .....	1
Diseases of heart .....	27
Aneurism .....	0
Abscess .....	0
Dropsy .....	8
Diabetes .....	0
Bright's disease .....	7
Peritonitis, gastritis and perforation .....	18
Hernia and obstruction of intestines .....	2
Diseases of liver .....	4
Genitourinary diseases .....	2
Hip disease .....	3

170

### IV—DEVELOPMENTAL DISEASES

Puerperal diseases not septic .....	3
Infantile debility .....	20
Dentition .....	1
Senectus .....	21

45

### V—DEATH BY VIOLENCE

Accidental .....	19
Homicide .....	1
Suicide .....	1

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Total deaths for January, 351. Total deaths for January, 1895, 433.

Annual death-rate per 1000 during the month (estimated population 330,279) 12.52+

# Cleveland Journal of Medicine

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No. 4

## Fracture of the Third Cervical Vertebra—Recovery

BY S. E. KAESTLEN, M. D., CLEVELAND

*Surgeon to Deaconess' Hospital; Surgeon in charge of Altenheim*

THE case which I am about to report this evening many of you have already seen and heard of; it is no fault of mine that some of our daily newspapers secured information of it. I believe the case is one not met frequently, at least with such favorable results as I shall report later on. The fortunate unfortunate as I have termed him, named Erwin Seidel, aged 14, always strong and healthy, with good family history, was run over by a heavy wagon on August 24th, '95. He sustained a comminuted fracture of the right thigh from the upper part of the lower third to the lower part of the middle third of the femur, a fracture of the inner condyle of the humerus, a fracture of the styloid process of the left ulna, a fracture of the left clavicle close to the articulation at the shoulder-joint, a fracture of the lower maxilla of the right side, at about the center between symphysis and ramus, a fracture of the skull in the left temporal region undoubtedly passing down into the petrous portion, and a fracture of the third cervical vertebra, with involvement of the fourth and fifth vertebrae, and various abrasions and contusions. With all this I am able to present him before you tonight with only the following defects: partial paralysis of the muscles of the neck, shoulder, thorax, and forearm on the left side; anesthesia of the integument of the right side, up to the median line of the scalp and neck, and a point of anesthesia on the dorsal surface of the right forearm at about the point where the musculospiral nerve becomes superficial. The history



of the occurrence and treatment of this case may be interesting to many present, therefore I shall give it from first to last as nearly correctly as is possible.

On the evening mentioned about 8:30 P. M. I had just left my office to go to a drug-store directly opposite, in front of which stood a band-wagon. In a few moments the driver started up his team with the aforementioned results to this boy, and injuring five others. The injuries of the others were only trivial; three were able to go to their homes unassisted and two I ordered sent to the hospital in the ambulance at the same time with this patient. I was asked to see him and found him sitting in a back room in the drug-store on a chair supported by some one and in a cyanotic condition; his head had fallen to one side and respiration ceased; I grasped his head and put it on a stretch and instantly respiration began. I could also feel a sensation as of crushed bone in the left temporal region and a frightful hemorrhage was continuous from the left ear. I remarked to a friend that this certainly was going to be a dead boy, but did not up to that time actually suspect any vertebral fracture, but did observe that so soon as the head was not supported it would fall to either side and respiration would cease, an experiment tried not more than once. I asked the same person to take hold and not let the head go until such time as I myself should tell him to do so. I then had the ambulance telephoned for and also sent for the lad's uncle, whom upon his arrival I asked to take care of the head while I went for such instruments as I deemed necessary. The ambulance having arrived in the meantime I ordered the patient taken to the nearest hospital, having also left messages for several physicians, but strangely none were to be reached. Upon arriving at the hospital and having the patient and two more of the injured on my hands I asked the boy's uncle to telephone for some physician at once. He called his family physician, Dr. C. B. Humiston. Up to the time of the doctor's arrival I had diagnosed the fractures of the femur and skull. We then both examined him and found the ulna and humerus fractured; after dressing the thigh, when putting him in a position favoring counter-extension, I had hold of his head making traction, and sustained it in a horizontal position, this being the position in which he was most free of pain in the back of the neck. I discovered a crepitus which seemed to be in the vertebrae and remarked it to Dr. Humiston, saying "We have certainly a fracture of the spinal column, I get crepitus." However, nothing further was said and the patient was placed in a horizontal position, the fracture of the thigh dressed by upper and lower metallic splints, and a long external splint and extension, and sand-bags on either side; the left arm was dressed with crinoline bandages and the left ear carefully cleaned and packed with boric acid and the head sustained by sand-bags on either side.

The treatment from this on was only an expectant one, both of us having given an unfavorable prognosis. The accompanying charts will show the

temperature and pulse rate. The urinary function was normal and remained so until up to about the third week, when after exertion and handling in cleansing the ear and back part of the neck, he suffered from retention of urine for twenty-four hours during which time I catheterized him three times, and again one week later when from the same cause retention occurred again his bowels were inclined to be constipated, and even rather strong doses of cathartics were required before the bowels were opened, and after being opened it was a question if we could get the tenesmus stopped. This fortunately lasted only about ten days. The immediate treatment outside of this was daily cleansing the ear with bichlorid solution and packing with boric acid. Internally potassium iodid and protiodid of mercury 1-10 gr. were given three times daily for about three weeks. During this time the head was kept upon the stretch, by laying a folded towel under the neck so as to



raise it some. As hope returned after the fourth day we placed the patient on an inclined plane to favor union of the femur. This new position placed the head in a flexed position on the chest, again giving us a form of extension, and sandbags were placed to sides of the head to secure the correct position. The fracture of the maxilla was not discovered until several days following the accident, when this was also dressed with crinoline. The clavicular fracture was not discovered until eight or ten weeks following the accident; during all this time the patient had suffered very little pain except in the neck whenever moved, and following the moving of the neck he had neuralgic pains in the region of the left shoulder and in the elbow and right wrist, which would pass away after two or three days, but in the region of the fractures no discomfort either during reduction or afterwards. The patient did not lose consciousness except at the time of the injury.

The immediate symptoms were complete paralysis of both arms and forearms, paralysis of the muscles of the left side of the face, and hypersensitiveness to touch; the left pupil was dilated, and there was no reaction to light; the left side of the neck was hyperesthetic, while on the right side of the face and neck motion was normal, but anesthesia complete; respiration was thoracic; chest-motion was very shallow but it gradually improved; slight hemorrhage persisted from the ear for five days. All bandages and splints were removed at the end of 4 weeks. At the end of the 8th week the faradic current was employed with massage which latter had been used for some time. About the tenth week the callus in the region of the neck had become very large so that it inclined the head to the left side and at the same time overstretched the sterno-cleido-mastoid and other muscles, and prevented them from counteracting the effect of the companion muscles of the opposite side. A plaster cast was therefore placed on the patient, entirely enveloping the head, chest and part of the trunk, our aim being to correct the deformity. It must not, however, be misunderstood, the patient being at this time able to walk around unsupported, and even to bring his head into the proper position, but could not retain it there for a longer period perhaps than  $\frac{1}{2}$  or 1 minute. This cast was removed and replaced by another at which time the callus was found to have diminished greatly, but having got the second cast too tight we removed it after several days time and having healed all friction and pressure sores, another cast was applied, suspending the patient's head and shoulders by bandages similar to those used by Sayre. After this cast had remained on for several weeks the patient felt well but had a slight difficulty in breathing during the first few minutes reclining.

The interesting feature of this case is the rarity of recovery from such a serious condition as a fracture of the cervical vertebra so high up, and associated with it the many other fractures, especially of the skull. I have been unable to find any case with which to compare this one in any literature at my disposal, and now in proof of this diagnosis, I want to offer first the cessation of respiration and following it the cyanosis and unconsciousness so soon as the head was not held in a straight line with the body, as nearly in the natural position as possible; the disturbed respiratory function for some days following the accident, and again occurring so soon as the neck was disturbed to any extent; and lastly the callus which extends from the region of the second, to that of the fifth vertebrae. In support of this I wish to call your attention to the recent work on Physiology of Professor Stewart of Western Reserve University; on page 175 in a paragraph marked "Relation of Respiration to the Nervous System" he says: "The respiratory movements are entirely dependent on the nervous system and the center which presides over them is situated in the spinal bulb. It is a bilateral center; that is, it has two functionally symmetrical halves, one on each side

of the middle line, and each of these two halves seems to have to do more particularly with the respiratory muscles of its own side; for destruction of one-half of the spinal bulb causes paralysis of the muscles of respiration on that one side only. Anatomically the respiratory center has not been sharply localized, but it lies higher than the vasomotor centers. It is brought into relation with the muscles of respiration by different nerves; the phrenic nerve to the diaphragm and the intercostal nerves to muscles which elevate the ribs. These are the most important in ordinary breathing, etc. Section of the spinal cord above the origin of the phrenic nerves causes complete paralysis of respiration and consequently death, and in man fracture of any of the four upper cervical vertebrae is, as a rule, instantly fatal; but in one case respiration was carried on by contractions of muscles of neck and shoulders for 30 minutes, while all below the shoulders was paralyzed." Another case is mentioned in the same physiology of a man carrying on an active life after the chest-wall had become fixed, he breathing only with his abdominal muscles and diaphragm.

We have as nerves of respiration the phrenic and pneumogastric. The origin of the phrenic nerve as given by Gray is as follows: it is formed by the third and fourth cervical nerves and sometimes receives filaments from the fifth and sixth; it is the motor nerve of the diaphragm. The second and third cervical nerves supply motion to the sterno-cleido-mastoid and trapezius muscles, and, assisted by the fourth, sensation to the neck and scalp. We have in this case, as you observe, a loss of motion in these muscles, also a loss of sensation of the scalp and neck up to the median line on the right side. The fourth and fifth cervical nerves give motion to the diaphragm, and sensation to the neck and shoulder. The fifth and sixth supply motion to the serratus magnus and the muscles of the shoulder; the fifth sensation to the shoulder; the sixth sensation to the arm; sixth, seventh and eighth motion and sensation to the shoulder, arm and hand. Here we find sensation of the arm impaired on the dorsum of the forearm, only at the point where the musculospiral nerve becomes superficial (where it is found anesthetic.) The brachial plexus is formed by the fifth, sixth, seventh and eighth cervical and the first dorsal nerves; from these facts we find in this case that there was injury to the second, third, fourth, fifth, sixth, seventh and eighth cervical nerves, and that this injury must have been bilateral. There is no question of fracture; all the phenomena presented which have kindly disappeared, I believe to be proof sufficient. The pneumogastric nerve supplies to an extent the organs of voice and respiration with motor and sensory fibers, as well as organs not affected in this case. We had a slight defect in the motor function of the pharynx and a change in the pitch of the voice, it being husky and coarser than it was prior to the accident. The posterior thoracic nerve arises generally from the fifth, sixth and seventh cervical nerves and supplies the serratus magnus with motion; this is the muscle

which, along with the intercostals, raises the chest-walls in inspiration, and in looking over our case we find we had an action of the chest-walls, although impaired; hence, we must infer that the injury did not extend as low as the origin of the seventh or perhaps the sixth cervical nerve.

A recent examination of the patient in March, 1896, shows some atrophy of the pectoral muscles, the serratus magnus, deltoid, biceps, rhomboid, and scapular muscles; sensation remains as stated above. The boy is able to carry his head in an almost correct position early in the day, but becomes exhausted later and assumes the position well shown in the accompanying photographs. This change in the position of the head to a correct one occurred quite suddenly March 14th, when he says something snapped on the unaffected side of the neck in the muscular portion. He is now wearing no support of any kind, nor has he for the last three weeks, and a gradual improvement is apparent in the power and size of the muscles.

*615 Lorain Street*

## LaGrippe with Pronounced Intestinal Complication

BY W. C. CHAPMAN, M. D., TOLEDO

**D**URING the past six months quite a number of cases of grip have come under my observation, which present peculiarities not noticed in former years. A member of our Association read a paper before the Northwestern Ohio Medical Association in which he asks the question, "Have we a new form of continued fever?" Doubtless he had been observing the same class of cases to which I refer. Not being present at that meeting I did not receive the benefit of his experience.

Briefly as possible I desire to present these cases to you tonight, and trust you will criticise that which I may say, as it appears to me we have not all drawn the same conclusions from our experiences.

In every case there has been a period, of longer or shorter duration, in which both mental and physical depression have been a marked condition. Dislike for the performance of routine duty eventuates in the desire to remain in bed, not by reason of pain or other symptoms of illness, but merely from indifference to surroundings. In other cases a slight chill with fever may be the first symptom, frequently complicated with soreness in the muscles and joints. A peculiar pain in the back of the neck with inability to rotate the head freely was noticed in the majority of cases. In others, very high fever with scarcely any prodromes, marked the beginning of the disease. In all of the cases I have seen anorexia was persistent from the beginning; one of the chief troubles was to compel the taking of sufficient food. The pulse was never rapid, in fact, there was no proper relation between the pulsations of the bloodvessels and the temperature. I have frequently counted the pulse

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at 90 per minute and of fair quality when the temperature in the mouth had been 104 deg. The skin had a sallow look, and the expression of the face was one of anxiety, very different from the one in typhoid fever. Sometimes the cheeks were decidedly flushed and the eyes evinced restlessness. There was partial stupor, not so profound but that it could be overcome and rational answers obtained to questioning. Vomiting was not a frequent trouble, but occasionally food would be ejected and nausea complained of. In nearly all cases some distension of the abdomen was present and caused distress. The bowels were usually constipated, but diarrhea in almost all cases followed laxatives. Looseness of the bowels in several of my cases was present from the first. Respiration was accelerated and as high as 40 movements of the chest per minute were noticed. Perspiration was not excessive, but the skin was often moist when the temperature was high. Urine voided normally, but of dark color and small in quantity. In one case there was complete suppression for twenty-four hours. The tongue was usually coated, but not, however, with the brown furring of typhoid fever. In no case was there sordes upon the teeth. Carphologia was pronounced in one patient, seen in consultation with Dr. Tracy, but not noticed in any of my cases. In former epidemics of la grippe compression over the thorax was a marked symptom; this season the distress seemed situated over the abdomen and was one of the chief causes of suffering, so I became anxious, always fearing lest peritonitis might develop and end the life.

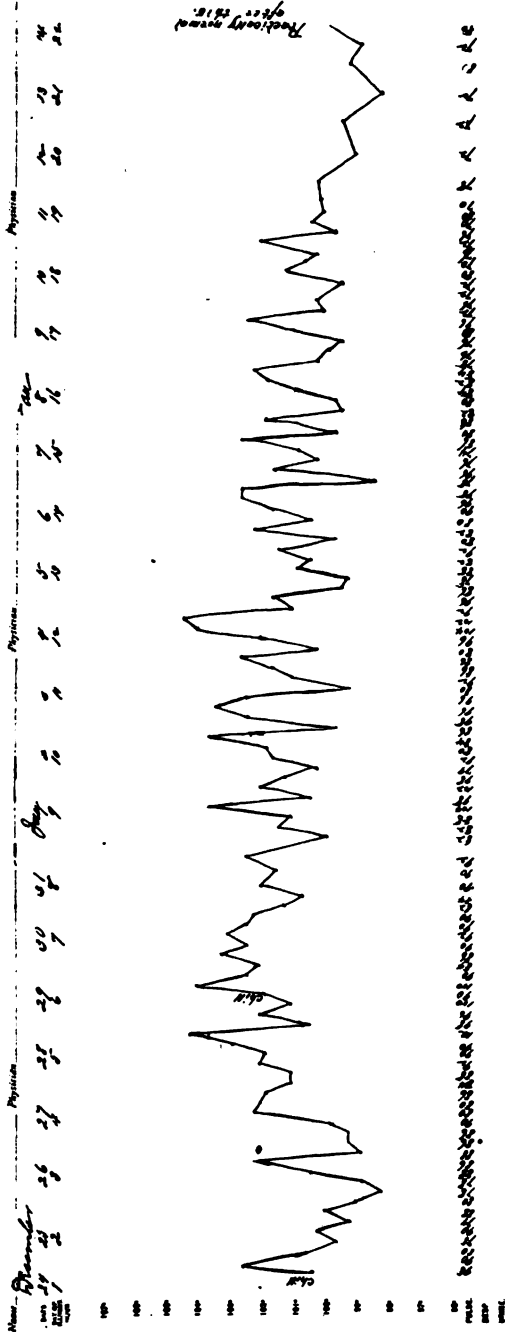
I have selected as nearly a typical case of this disease as came under my observation, every symptom being marked. From the study of this one a knowledge of others may be gained. This case could easily be taken for one of typhoid fever and I believe it would be excusable at the onset or first week of the course of this disease if such diagnosis be made. Lenticular rose-colored spots upon the anterior surface of the trunk are, when present, pathognomonic signs of typhoid fever, but they are not always found in that disease. In their absence the totality of signs and symptoms must be the only guide to a proper diagnosis.

I was called on the evening of December 24th, 1895, to see a patient who had gone to bed with a severe headache and nausea and feeling depressed and very ill. The patient was a woman in robust health, not having been sick for years. The pulse was 98 and temperature 100 deg. The skin was dry and the bowels constipated. She complained of severe pain and soreness over the whole body, especially in the dorsal and cervical regions. I prescribed aconite tincture 2m every two hours and  $2\frac{1}{2}$  grains each of phenacetin and salol every three hours. I was called at 11 o'clock the next morning; the temperature at midnight had been 102.8 deg. but now was 98.8 deg.; the pulse was 74 and full. I prescribed calomel 5 grains, to be followed by half an ounce of Rochelle salts at bedtime, and liquid food. I called next day, the 26th, at noon; the temperature at midnight had been 100.2 deg. and pulse 88.

TOLEDO HOSPITAL.

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I continued capsules. She was still constipated and did not sleep well. At my noon visit on the 27th, the midnight temperature had been 99 deg. and pulse 88; the patient was depressed. I prescribed strychnin sulfate gr. 1-30 with quinin sulfate gr. 4 every four hours, and continued capsules. On the 28th, at my noon visit, the midnight temperature had been 102.4 deg. but fell to 101.2 deg. at four o'clock, and was now 102.2 deg., and pulse was 92. The patient complained of want of sleep, with much tenderness over the abdomen and sharp pains on pressure, also her bowels had not moved. I ordered the quinin and strychnin continued, turpentine stupes over the abdomen and a Seidlitz powder, to be followed by another, if her bowels were not moved. I saw her again at six o'clock, when her bowels had moved slightly. I prescribed sulfonal gr. 15, to be repeated in the night, if sleep was not produced, but the last dose was vomited. On my visit on the 29th, at midnight her temperature had been 104.4 degs., pulse 112. Four A. M., temperature 100.6 deg., pulse 98. I ordered Rochelle salts  $\frac{1}{2}$  ounce, and if not effective, a saline enema at noon. The bowels were very much distended. At my visit at 5 P. M., the patient was just experiencing a severe chill, but her temperature was increasing, and on my evening visit I found the thermometer registered 104.2, while the pulse was 100. The enema had been repeated with good result, much gas passing; the abdomen was, however, still much distended. I ordered a repetition of the 15 grain doses of sulfonal at eight and again at ten o'clock, if necessary, and, these failing to procure sleep,  $\frac{1}{4}$  grain of morphin sulfate was to be administered at midnight, hypodermically. On my morning visit of the 30th, the midnight temperature had been 102.4 deg. and pulse 90. She had rested well, but the bowels were confined and the abdomen tympanic. I prescribed calomel 5 grains, to be followed after dinner with a Seidlitz powder. The bowels had not moved by evening, and the patient had a poor day, her face restless, evincing great anxiety and distress. I prescribed a saline enema, and a continuation of former treatment. At my morning visit of the 31st, she showed no improvement in general condition. Her midnight temperature had been 102 deg. and her pulse 82. At eight o'clock A. M. the temperature was 100.8 deg. and pulse 84. There had been good results from the enema, much gas was passed with feces. There remained, however, much distension of the abdomen.

I have given enough of the case to show the great variation of temperature so far, and outlined the treatment, as given by the bedside notes, of the patient. It would be tiresome to give you details clear through to the end, which happily resulted in recovery. From the first of January, the day we break this written record, up to the 11th, much the same record of temperature and pulse presented itself, with distended abdomen and depressed condition of the patient. On the 4th, at eight o'clock in the evening the thermometer showed 104.6 deg., the highest point reached during the sickness. An immediate fall occurred, so that at noon of the 5th, 99.4 deg. was



noticed, the pulse was 102 and 78 respectively. After this there was not noticed any rise or fall occurring rhythmically, the variations having no reference to the hour of the day. Gradually the tympanites disappeared and the temperature and pulse became normal. Convalescence was established fully by the 27th day, when I ceased visiting the patient.

The treatment all through the course of the disease was as indicated above, attention being particularly given to the condition of the bowels. Rochelle salts and saline enemas with calomel, two or three times, usually occasioned free evacuations and the escape of quantities of gas. Stupes well applied were constantly kept over the abdominal surface. Sulfonal or sulfate of morphin hypodermically produced sleep without bad after-effect. Salol, phenacetin, quinin and strychnin were administered through the course of the disease. Little food could be tolerated, but milk, oysters, chicken-broth and the like were forced upon the patient. Digitalis appeared to relieve the congested kidney and established the secretion of urine.

Gentlemen, the above case typifies true influenza, called grippe, with a marked manifestation of intestinal involvements. I know no disease that will, when severe, worry the physician more when desiring to establish the proper line of treatment, and to give an intelligent opinion as to prognosis to the friends. Some days every symptom seemed to indicate improvement, but by the next visit a change was apparent and so all would be discouraging.

The line of treatment as given in this paper seems to have been successful with me in a majority of cases; but in two cases, seen in connection with Dr. Tracy, death came, and it seemed as though the patients succumbed merely from depression, perhaps of the nervous centers, occasioned possibly by an overwhelming poisonous action upon them by an unknown power, which we call "germs."

## Our Public Schools

BY DR. H. G. SHERMAN

A short time since the director of our public schools presented a financial statement of the funds at his disposal for the consideration of the educational committee of the Chamber of Commerce, which stands for all that is uplifting and ennobling in the community. The committee considered the director's request for an increase in our school-levy and answered that it was not necessary, although they maintain a broad, liberal view of matters affecting education, believing that the progressive work of the public school is essential to the development of a better citizenship and a higher civilization. They would save forty thousand dollars by abolishing German; five thousand dollars in the payment of fees. They would save seventeen thousand

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dollars diverted to the police fund. They object to the payment of interest from the general fund on the bonded indebtedness amounting to eighty-seven thousand dollars. They recognize that it costs money to maintain the departments of manual and domestic training, and an increase in the salary of teachers has been made. In fact there is no reason why, from their standpoint, there should not be a surplus of fourteen thousand dollars from the funds already subject to the school council, notwithstanding the fact that they recognize that there are two thousand students annually applying for admission who cannot be properly housed; and this notwithstanding the fact that to meet this increase forty-five new rooms should be added annually to our school-room capacity at a cost of one hundred and thirty-five thousand dollars. I shall not involve myself in controversy by discussing the relative merits of the positions assumed by the director and the committee on education in the Chamber. It shall be an open question. No one who engages in a serious study of the period of transition through which our civilization is passing at the present time, can resist the conclusion that we are rapidly approaching a time when we shall be face to face with social and economic problems graver in character and more far-reaching in extent than any which have been hitherto encountered.

No one can point the direction in which the path of future progress lies; that the times are pregnant of great changes, the least observant must be convinced. The reign of the demagogue is apparent and the sober, intelligent sense of the people lies dormant. It is time that *this* community should be aroused to a realization of the actual conditions which obtain in our public schools, affecting the intellectual, moral and physical welfare of forty-six thousand students enrolled, more than three thousand of whom are in basements and hired rooms, the sanitary conditions of which imperil their lives, where all laws of physiologic optics and hygiene are set at naught.

I had prepared a paper, Mr. President, on the subject of myopia, its abnormal increase during student life, but sir, since I have become intimately acquainted with the hygienic conditions existing in our schools I have abandoned it and shall take the liberty of addressing you as a citizen and a parent, believing sincerely in the grand mission of the public schools, in their patriotism, in the magnificent lessons of democracy inculcated, believing as I do that in a great country of sixty-five millions of people, made up of a heterogeneous mass from everywhere, holding conflicting views on all the great religious, political, social and economic problems of the day, the public schools are indeed the bulwark of our nation; that the genius, integrity and perpetuity of our institutions depend upon the uplifting and education of the masses therein gained.

In our lack of civic pride, we are indifferent as to whom we shall choose as our mayor and councilmen, though they disburse hundreds of thousands of dollars annually. We do not care, notwithstanding the fact that we are

living in an age dominated by a commercial spirit, but, sir, when we are indifferent as to who shall assume the guardianship of forty-six thousand children, whose health, ambition and future usefulness to themselves and to the state so greatly depends upon the character, broad intelligence and deep sympathy of the director of our public schools, powerless, unless backed by a legislative council of equal merit, we are bordering on the criminal. I shall not discuss past boards. Honorable men have been among them, but, sir, their work is in evidence, and is a stench ascending to high heaven, a pollution, which should be permitted to degenerate in peace without further agitation. Let us enter a typical school-room and study those conditions which affect sight and figure. Let us consider those changes in the functions of the visual organs which are immediately developed under the influence of school-life. Decrease in the range of vision or short-sightedness is one of the most common. I need not enter into details as to what constitutes myopia before this body; it is essentially a pathologic condition; it is incurable, and is progressive under unfavorable conditions, not infrequently leading to blindness. Myopia is developed almost exclusively during school-life, rarely afterwards, and very rarely before that time. Is this coincidence of time accidental, that is, does the short-sightedness arise at the period during which children go to school, or has school-life caused the short-sightedness? Statistical inquiries prove the latter to be the case, and have shown at the same time that the percentage of short-sighted children is greater in schools where unfavorable optical conditions prevail.

It is true that short-sightedness is often hereditary, but this must not be thought to mean that the children of short-sighted parents are born short-sighted. They have only the predisposition to become so, and this predisposition is developed during school-life, more or less, according to certain external conditions; and the more so, of course, under conditions which tend to produce short-sightedness even in children who have no hereditary predisposition.

If the predisposition is thus hereditary and new cases are continually added, we can easily understand that short-sightedness in general must be continually on the increase. This, with regard to civilized countries, is an established fact. Short-sightedness has an injurious influence on the general health by inducing a habit of stooping; its increase, from a national point of view, is to be considered a serious evil. In former times, when literary education was confined to a small number, this question was of little or no importance; now that education is universal, and the safety of the Republic depends on its enjoyment, the question, how to prevent short-sightedness, is of serious consideration. It has been determined by Professor Risly, of Philadelphia, that the increase of myopia in the public schools of their city is from one and four-tenths percent in the primary grades to twenty-

eight and nine-tenths percent in the grammar grades. Let us now consider the subject of asthenopia, in other words, a decrease of endurance. This very frequent affection, which has destroyed many a career, prevented the development of many a fine intellect, and deprived many of the fruit of their laborious exertion and persevering industries, arises principally from two causes, one of which we may consider. It arises, namely, from a disturbance in the harmonious action of the muscles of the eye, a defect which is difficult to cure and which is generally caused by unsuitable arrangements for work, developing what is popularly known as eye-strain, although the eyes may be free from defect. The various factors of eye-strain may be summarized thus: first, ocular defects, including ametropia and insufficient power of accommodation; second, improper requirements in the way of eye-work, including excessive hours of eye-work, inferior illumination, imperfect adjustment, wrong position of the object and wrong arrangements of hours of work and recreation; third, defects of general nutrition; fourth, imperfection of the organization of the nervous system, or degenerative changes in it, including the influence of sudden changes in the amount or kind of eye-work.

The next point to which your attention is asked is that the intensity of the eye-strain is not directly proportional to the ocular fault that gives rise to it. The former may even seem inversely proportional to the latter. An ocular defect may give rise either to imperfect vision or to eye-strain. It is the higher degrees of ametropia that necessarily cause imperfect vision, while the lower, in which imperfect vision can be obviated by increased exertion, more commonly cause eye-strain.

Accompanied by Dr. Wirt and Mr. Newman, an expert optician of the Solomonson Optical Company, armed with kodaks, trial lenses and Snellen's test-types, we invaded the schools. The morning of the examination was absolutely perfect, the sun shone from a cloudless sky. A grammar grade was chosen. The rooms contained forty-four pupils, ten of whom had normal vision, seven had simple far-sightedness, sixteen myopia, and twelve compound astigmatism. This room was most favorably situated as regards light.

In another room, eleven enjoyed normal vision, five simple far-sightedness, nineteen had myopia, and seven compound astigmatism. In another room we found that thirteen in fifty had compound myopia. In another room twenty-one in forty-six had seriously defective vision; in another, fourteen in forty-seven; in another, thirteen in forty-three. When we visited the high school, we were permitted to visit the thirty rooms accompanied by Professor Harris, who granted us every courtesy.

It is greatly to be regretted that so intelligent a man, one so conscientious in his duty, appreciating fully the unfavorable conditions of heating, ventilating, lighting, arrangements of desks, etc., under which his pupils are working, should be unable after many efforts to have these conditions corrected.

We selected a typical room and made a careful examination for anomalies of refraction. In a word, thirty-one of the thirty-seven pupils in the room had defective vision. We found in the afternoon that the pupils were working by artificial illumination.

Now, gentlemen, let us consider in conclusion, what this increase in taxation demanded by our director means to us as a community. I find, upon application to our county auditor, that sixty persons in every one hundred, or four-sevenths, pay less than fifty dollars annually in taxation in the corporate limits of our municipality; that forty-five in every one hundred, or four-ninths, pay less than twenty-five dollars annually. Assuming that sixty out of one hundred pay the full fifty dollars, what does it mean? Simply that they are contributing twelve dollars and fifty cents a year towards the education of their children. Again, if you please, assume that forty-five in every one hundred pay the full twenty-five dollars, what does this mean? It means simply that they are contributing six dollars and twenty-five cents towards the education of their children.

Considering the matter in the light, that the paramount question under consideration in every family in this town is, what privileges may we give our children that we have not ourselves enjoyed, can we afford an increase in our school levy?

Much of the above has been taken from recognized authorities, especially that relating to myopia and eye-strain.

## Empyema of the Accessory Cavities of the Nose

BY JOHN M. INGERSOLL, M. D., CLEVELAND

**E**MPYEMA of the accessory cavities of the nose is not so rare a disease, I think, as some are inclined to suppose, and a brief consideration of this affection may be of interest to us all.

First, let us look at some of the symptoms which would lead us to suspect suppurative trouble in one or more of the accessory cavities. Headache is a very common subjective symptom and may be constant or intermittent and more or less localized or diffuse. The headache may be caused by the retention of purulent matter in one of the cavities, particularly the frontal or sphenoidal; or simply by the irritation caused by the pus in the cavities and the nose.

Facial neuralgia is also frequently present and is usually a very distressing symptom. A purulent or mucopurulent discharge from the nose or in the pharynx or nasopharynx, which continues for a considerable length of time, should make one suspicious of an empyema, especially if the discharge is unilateral.

The constant irritation of the pus may cause marked hypertrophy, so that the patient complains of one side of the nose being "stopped up," if the infection be confined to one side, and of both sides if bilateral.

A bad taste in the mouth is an almost constant symptom, as the purulent secretion flows down the pharynx, especially during sleep, or is drawn down and back by inspiration. The patients, themselves, may often perceive the unpleasant odor.

Polypi, whether they are caused by the irritating effect of the pus on the mucous membrane, and are thus secondary, or whether they are primary, and by pressure obstruct the openings of the cavities, thus causing the disintegration of the lining membrane and suppuration, are of such frequent occurrence in empyema as to warrant a strong suspicion of purulent infection of the accessory cavities.

Toothache is frequently present and is to be considered as an effect rather than a cause, for dental caries is by far the most common cause of empyema of the antrum.

Having thus briefly outlined the most prominent symptoms of empyema let us consider the diagnosis and treatment.

As the antrum of Highmore is most frequently affected, we naturally suspect this cavity first, and proceed to establish the diagnosis of affection of this cavity, or to exclude it. On looking into the nose, all polypi having been removed if present, we see an inflamed and hypertrophied mucous membrane, covered with a more or less profuse purulent secretion. If this secretion is carefully but thoroughly removed and a little ten percent solution of cocain applied, our field of vision is considerably increased, and if pus again appears in two or three minutes, we may be sure that it comes from one of the cavities and not from the mucous membrane itself.

A drop of pus usually appears on the superior surface of the lower turbinate bone toward the anterior part of its middle third, as the opening of the antrum and the mouth of the duct leading to the frontal sinus are situated in the middle meatus, just above the middle third of the inferior turbinal. It may happen that the antrum has a second opening farther back in the middle meatus, and in such cases the flow of pus may be backward toward the nasopharynx, so that while the anterior part of the nose is partially or entirely free from pus, posterior rhinoscopy will show the posterior part of the inferior turbinate body covered more or less with a purulent discharge.

If, now, the nose is thoroughly cleansed of all pus, and the patient bends the head forward and down, with the suspected side uppermost, the natural opening of the antrum is lowered while its floor is raised and at the same time the opening of the frontal sinus is raised, and if the head is shaken a little, any fluid in the antrum will tend to run out into the nose, and if we examine the nose immediately and again find pus on the inferior turbinal, we are certainly justified in making an exploratory puncture into the antrum, and so establishing a positive diagnosis. To make the experimental puncture, we first cleanse the nose thoroughly and cocaineize the inferior meatus and then pass the trocar back to about the middle and directly under the inferior turbinal. If the outer end is now pushed well over against the septum and at the same time depressed, and the point of the trocar is brought well up under the inferior turbinate body and against the plate of the maxillary bone, which is very thin at this point, a slight force exerted outward, upward and backward carries the trocar into the antrum. The cavity is now washed out, preferably

with a normal salt-solution, by means of a syringe attached to the trocar, and the solution allowed to flow out through the natural opening of the antrum into the nose and thence into a clean pus-basin. If the solution comes out clear, we may be sure that the antrum is not affected, but if pus is mixed with it, the diagnosis of empyema of the antrum is established.

The experimental puncture is so easily accomplished and gives such positive results, that I think it should be made in all suspected cases of empyema of any of the accessory cavities of the nose.

In regard to 'transillumination' with an electric light in the mouth as a means of diagnosis of empyema of the antrum, I can only say that after seeing it frequently used, and having had opportunity to use it myself in several cases, the results are so uncertain that I am compelled to regard it as of little practical value.

Having established the diagnosis of an infection of the antrum, we may proceed to make a permanent opening for cleansing and draining the cavity.

The favorite method of Prof. Chiari, of Vienna, is to remove the first molar or second premolar tooth, especially if these are at all decayed as is almost invariably the case, and then to bore into the antrum through the socket of the tooth. This method has the advantage of establishing drainage at the lowest part of the antrum. The cavity is then washed out twice a day with a mild antiseptic solution, and dried somewhat by forcing a little air through after syringing. It may then be packed with gauze, or left with only a little piece of gauze in the artificial opening to prevent closure, according to the opinion of the operator.

However, in regard to establishing a permanent opening of the antrum there is a diversity of opinion, and many favor the operation through the canine fossa, or Mikulicz' operation, in which the antrum is opened from the inferior meatus, just below the anterior end of the inferior turbinal. If the cleansing of the cavity twice daily with a mild antiseptic solution, and the establishment of free drainage do not yield the desired result, different solutions should be tried, and the insufflation of such powders as boric acid, dermatol, iodoform and others. Cases of long standing are however, frequently very obstinate, and in such cases probably the best treatment consists in making an opening through the canine fossa, large enough to permit a thorough curetting of the whole cavity and then packing it with gauze.

The cavity which is next most frequently affected is the frontal. The opening of the frontal sinus is at its base, so that any hypersecretion in it tends to flow down into the middle meatus and over the lower turbinal. If the antrum has been washed out and the nose cleansed, and pus still appears along the superior surface of the lower turbinal, we may be reasonably sure that it comes from the frontal sinus, especially if the patient complains of tenderness in this region and frontal headache. On account of the middle turbinal projecting forward beyond the opening of the frontal sinus, it is usually a difficult task to pass over a small probe into the sinus, and almost impossible to introduce a small tube for the purpose of washing it out, so that the first step in the treatment is the removal of the anterior end of the middle turbinal. This makes it possible to thoroughly cleanse the cavity and gives free drainage, which is usually enough to relieve all the symptoms, for as a rule frontal empyema of itself does not cause much trouble until there is some obstruction of the duct causing retention, and if this obstruction is not speedily removed we may have severe complications; the most prominent

of these are involvement of the eye, the pus working down toward the eye as the wall of the frontal sinus is thinnest in this direction, and the presence of a fluctuating tumor, causing displacement of the eye, or interference with its movements and function. The pus may penetrate toward the brain and cause meningitis or cerebral abscess which naturally, almost invariably, causes death. In such cases, if free drainage cannot be immediately established through the nose, the cavity should be opened externally and treated according to general surgical principles.

The ethmoidal cells consist of two groups, the anterior, which open into the middle meatus a little farther back than the duct of the frontal sinus and the posterior ethmoidal cells, which communicate with the superior meatus. The infection of these cells is almost invariably secondary to that of one of the other cavities, and the diagnosis is not so easy to establish positively; but if we wash out the antrum and frontal sinus and then find pus still appearing in the middle meatus and if we can with a probe find friable and necrotic bone in the region of the ethmoidal cells, we may feel reasonably confident of empyema of these cells, and are justified in introducing a delicate but strong curet and scraping out the cavity and all carious bone, and cleansing with an antiseptic solution. The irrigation should be continued as long as the purulent secretion lasts.

Of all the accessory cavities of the nose, the sphenoidal is least liable to be affected, and this is fortunate for it is the most difficult to diagnosticate and treat. Among the symptoms to which empyema of this cavity may give rise are occipital headache, vertigo and tinnitus. Pus appearing in the vault of the pharynx should make one suspicious of sphenoidal empyema; and when there are two cavities, the pus may be more abundant on one side of the vault if only one cavity is affected, for the openings of these cavities are usually situated near the septum and the pus naturally flows down into the nasopharynx.

The most certain means of diagnosis, here as in the antrum, is the experimental puncture made with a trocar with a sliding projection, so that the danger of pushing the needle too far into the cavity is avoided. If pus is found, or if necrotic bone can be felt with a probe, the cavity should be opened and all dead bone removed if possible. To do this it is often necessary to remove the greater part of the middle turbinate bone. After opening the cavity it should be cleansed and packed and the same line of treatment followed as has been indicated for the other cavities.

Finally, let us briefly repeat the general line of procedure and treatment in empyema of the accessory cavities; the antrum of Highmore should be the first cavity suspected and the positive diagnosis made or excluded; then the frontal sinus should be considered in the same way, and then the ethmoidal and sphenoidal sinuses.

The treatment consists in establishing free drainage and thorough cleansing. It is hardly necessary to add that the condition of the patient's health generally must also receive our attention and that general constitutional treatment must in all cases be administered according to indications.

*50 Euclid Avenue*



## Hydatid of the Liver

*Case presented to the Toledo Medical Association by Dr. Donnelly.*

THE boy, aged 12, had good health until a few weeks before he was presented for examination. When seen he was anemic and pale, his skin was cold and clammy, eyes sunken, and he had a wasted appearance due to pain. A few weeks ago he was taken with gastric disturbance, nausea, vomiting, and abdominal distension. This distension was principally in the epigastrium and umbilical area. The superficial abdominal veins were engorged with blood and could be easily traced.

On percussion of the abdomen there was complete dullness over the area of the tumor; it extended from the right axillary line to the median line and from the seventh rib to a line drawn from the anterior superior iliac spine. The tumor was hard-elastic to the touch and nodular. The tumor was movable with the liver, that is, the tumor could not be moved unless the liver also moved, showing that it was in direct connection with or sprung from that organ.

Examination of the blood gave negative results, as did also examination of the urine. The patient was put upon an alterative treatment, *viz*: mercuric bichlorid 1-30 gr. with bitter tonics. Exploratory operation was advised but the patient would not allow any operative procedure. He has improved upon the alterative form of treatment, and when last seen the tumor had not changed, except that it was more nodular than before.

The boy has now a good appetite, and all gastric disturbances have ceased. His bowels move naturally and the feces are of a normal color. The urine is normal. He still complains, however, of considerable frontal headache.

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*Reported by Dr. W. W. Brand*

# Cleveland Journal of Medicine

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AND OF THE UNION MEDICAL ASSOCIATION OF NORTHEASTERN OHIO

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## EDITORIAL

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### Health versus Intellect

THE paper by Dr. H. G. Sherman on our public schools which appears on page 149 of this number of the *Journal* is a very timely one. The ill effects of a sedentary life, though not in childhood so immediate, are much deeper and more lasting than in later years. Statistics show plainly that city families die out and are constantly replaced by hardier stock from the country. The secret is contained in two words, air and exercise. The problem of civilization is largely how to obtain these two God-given blessings, and at the same time the advantages of contact with their fellow-men which accrue to those who live in cities. Sound and undegenerate bodies depend more on the conditions which obtain during school-life than do well-trained minds. Not much science, but common-sense is needed to determine whether the conditions in any school are adapted to maintain rather than to vitiate the health of the pupils.

A visit to the Central High School in Dr. Sherman's wake develops some points of special interest. To save the expense of another much-

needed building the factory double-shift system has been introduced. Eleven hundred pupils in this building imbibe education and exhale carbon dioxide in the morning, six hundred others absorb effluvia and knowledge indiscriminately in the afternoon. The legitimate effects of this system are best seen in the pale faces of the teachers, who enjoy its cumulative action from year to year. The unfortunates who come on duty in the afternoon have the worst of this arrangement, as they march into the dust and dirt left by the morning contingent, and as they have less light, especially in the winter. A wise economy is maintained also in this matter; in each room are provided four gas-jets, which make the gloom but not the type visible.

The desks at which the pupils do their work vary in size with the grade of the school in which they are used. In other words they are carefully adapted to the stature of the pupil's mind, not of his body. The scholar who happens to have a long body and a short mind draws his knees up under his chin, and is apt to get a crook in his back, when he ought to be only building gables on his intellect.

Some of these faults are easy to overcome, others are not so easy. An adjustable desk is a simple problem enough and should be provided at once. If not the school authorities, then the people should see the disastrous results of misplaced economy in our schools, and provide enough buildings to accommodate not only the High School pupils without doubling, but also to release from bondage the three thousand pupils of lower grade who languish at present in basements, in this enlightened city of Cleveland.

To provide a really adequate system of ventilation may be a difficult matter, especially if it must be adapted to old buildings. Fairly good ventilation is not much to require, and is absolutely essential to the health alike of pupils and teachers.

The State undertakes to say that every citizen shall educate his children, if not in private, then in the public schools. This is a virtual contract on the part of the government to furnish good instruction to its children; and if when they ask for Arithmetic they are given a curvature of the spine, and when they ask for Latin they are given a pair of bad eyes, then is education become a burden. The plain fact is that the State is stultified and her future citizens receive a permanent handicap by such a schooling. The old saw might be amended to read: Better an ounce of good plumbing than a pound of antitoxin; better a foot of large type than a yard of spectacles;

better a well-made desk than several plaster jackets. (These might well serve as mottos for some of our public buildings.)

Light and air are the only forms of property to which most of our children are born. They are the capital from which they draw an abundant income of health and happiness. To swap them for book-knowledge may be a fair exchange; it surely ought not to be compulsory.

Let it not be thought that we make these remarks in a spirit of exaggeration, or as wishing to overrate the hygienic defects of our schools. God's sunlight does filter into many of them; in many of them carbon dioxid is not the staple furnished to the lungs; in many no doubt, a healthy boy may study half an hour without a headache. But it is hard to overrate, and easy to underrate the damage which one viciously built school-room may do. While there is a single pupil in a basement-school in Cleveland, that school will stand as a reproach to our much-vaunted system of public education.

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### The Board of Medical Examination and Registration

ON the afternoon of March 19th Governor Asa S. Bushnell sent to the Senate for confirmation the following names of physicians to constitute the Board of Medical Examination and Registration: John K. Scudder, Hamilton county, one year; Cady Markley, Lucas county, two years; S. B. McGovran, Harrison county, three years; David Williams, Franklin county, four years; Charles A. L. Reed, Hamilton county, five years; H. E. Beebe, Shelby county, six years, and N. R. Coleman, Franklin county, seven years.

Dr. John K. Scudder, of Cincinnati, is an eclectic, a graduate of the Eclectic Medical Institute, of Cincinnati, in the year 1888. Dr. Cady Markley, of Toledo, is a physio-medical. Dr. S. B. McGovran, of Cadiz, is a graduate of the University of Wooster, in the year 1872. Dr. David Williams, of Columbus, is an eclectic graduate of the Cincinnati school in the year 1870. Dr. C. A. L. Reed, of Cincinnati, is a graduate of the Cincinnati College of Medicine and Surgery in the year 1874, and is well known to the profession. Dr. H. E. Beebe, of Sidney, is a homeopath, a graduate of the Huron Street School in 1873. Dr. N. R. Coleman, of Columbus, is a graduate of Bellevue in the year 1870, and is well known to the profession.

The list shows that the eclectics made good their statement that they largely outnumbered the homeopaths in the state. The pledge to the physio-medicals is also made good.

The profession of Cleveland regrets that, while Columbus and Cincinnati each secure two men on the board, this city, which did so much for the passage of the law, receives no recognition whatever. In fact, only one man comes from the northern half of the state, namely the physio-medical from Lucas county. The profession regrets still more keenly that the appointments have been made on entirely similar lines to the political appointments of recent years.

The first meeting of the Board was held on March 25, nearly the whole meeting being occupied by the election of a secretary. After 29 ballots on 18 candidates Dr. Frank Winders of Findlay was elected.

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### Ohio Wesleyan University

THE commencement exercises of the medical department of the Wooster University, now the medical department of Ohio Wesleyan University, were held at Unity Church on the evening of March 18. The church was well filled with the friends of the students and of the college. The address to the class was delivered by Dr. H. C. King of Oberlin, and was closely listened to throughout. The degree of M. D. was conferred on twenty-nine graduates of this year, of whom two were women. The diplomas were presented by President Sylvester F. Scovel. Following the exercises a banquet was given by the faculty to the graduating class and alumni at the Forest City House.

The following toasts were responded to and much enjoyed by those present: "Post-Graduate Work," President Sylvester F. Scovel, President of the University; "Charity," Prof. H. C. King; "Law and Medicine," Mr. H. C. Bunts; "The New Doctor," Dr. J. C. Fritch.

The following are the members of the graduating class: Samuel Parrish Boardman, Hamilton F. Biggar, Jr., Arthur Edward Chatfield, Charles C. Dreyer, David Harold Eagleson, George Howard Fuller, Joseph C. Fritch, Albert B. Frazee, William B. Graff, William H. Hyde, Cliffe Frances Theodosia MacDonald, David Hervey Morgan, Thomas Joseph Updegraff Johnson, David Robert Kline, Frank Theodore Kopfstein, Mizer, Andrew Joseph McNamara, John Church Nash, Rosa Lee Oxer, Stephen W. Perry, Edwin H. Rea, Sumner C. Sackett, E. Howard Shildrick, Henry B. Stotter, Fred. P. Sprague, Frank E. Thompson, Edward B. Woodard, Arthur Winter, Norman Carey Yarian.

WITH this issue of the JOURNAL are presented the first of our letters from special correspondents in the various cities in or contiguous to the State of Ohio. This is a new feature, which we hope our readers will appreciate, and which we propose to extend until we regularly publish the news of all these cities. It is proposed to make this JOURNAL the medical newspaper of the Central States. We appreciate the fact that, besides scientific matter, the profession demands to be informed fully of what is going on in medical affairs in our own vicinity and elsewhere. This demand the JOURNAL proposes to meet as fully as possible. With regular and capable correspondents in Pittsburg, Toledo, Columbus, Cincinnati, Buffalo, and other cities we shall be able to give at first hand the very best information attainable concerning medical affairs in these cities.

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THE Cleveland General Hospital has for some months been subject to the depredations of the most extraordinary organized gang of thieves which has been unearthed by the police of this city in many years. A strange feature of the affair is that the exposure of the gang was accidental. In raiding a disorderly house recently the police found a large quantity of linen, bedding, and carpets belonging to the hospital. A male nurse attached to the hospital was also caught in the raid. Another nurse and three outside accomplices were soon apprehended as having been engaged in the robbery. All have been given good sentences in the Workhouse. In all the gang had stolen several hundred dollars' worth of property, most of which was recovered.

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SENATOR JONES has introduced a bill in the State Legislature to substitute execution by electricity for the death penalty by hanging. It is to be hoped that the measure will become a law, as the New York experience has clearly shown that electrical execution is instantaneous, painless, and humane. It is the modern method of inflicting the death penalty. On the contrary, death by hanging is seldom instantaneous, always painful, and very far from humane. Horrible exhibitions, like that in St. Louis early in March, where at a hanging the rope broke, and the poor victim had to await the arrival of a new rope, suffering acutely from a torn neck, and finally dying by strangulation, are all too frequent. Execution by electricity has been so perfected that accidents are nearly impossible.

AT the joint meeting of the faculty of the Wooster Medical School and the trustees of the Ohio Wesleyan University, held on Friday, March 21, the pending arrangements were completed for the transfer of the medical school to that institution. A new college building is to be erected, for which over half of the requisite funds have been raised. It is hoped that the remainder will soon be subscribed. The new building will be erected next year. At the joint meeting the faculty handed in their resignations in a body and were formally reelected by the trustees. The officers of the faculty are to be a president and secretary, elected by the faculty, and the dean appointed from the faculty by the trustees. These two offices may or may not be held by the same person. The action of the trustees was made on condition that the building be erected by the faculty or by residents of Cleveland on or before November 26th, 1897. The arrangement is sure to prove advantageous to both school and university.

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### Our Pittsburg Letter

Pittsburg, March 13th, 1896

Pittsburg and Allegheny, divided only by the river, form practically one city, with a population of about 400,000. Agitation for the "greater Pittsburg," which has been going on for the past few years, has, in a large measure, subsided. From a sanitary point of view this proposed consolidation would have been very desirable. Each city has its own waterworks. Both derive their water-supply from the Allegheny River; both furnish water which is clearly unsafe to drink. Allegheny enjoys the unenviable distinction of exhibiting the highest mortality rate from typhoid-fever of any city in the United States, it being about ten times that of London, while Pittsburg is only a little better.

A joint water commission, composed of engineers, chemists, and physicians, made an exhaustive report on the water supplies of these two cities a couple of years ago, pointing out their dangerous character, and recommending sand-filtration as a remedy. After many long months of constant agitation by physicians and a few intelligent laymen, and especially by the *Pittsburg Medical Review*, which deserves the highest praise for its work, it seems likely that both cities will adopt sand filtration; and since the "greater Pittsburg" does not now seem near, two plants will probably be erected, one by each city.

Some months ago the city of Pittsburg started a bacteriologic laboratory, with Dr. George B. Taylor in charge, in which any physicians in the city can have an examination made for the bacillus of diphtheria, or be furnished with the antitoxin for that disease. The advantages of the laboratory are denied to those physicians living across the river in Allegheny.

There is an awakened interest in sanitary matters here. The Woman's Health Association, which has been engaged in agitating sanitary reforms for a number of years, will have a powerful help in the Social Science Committee of the newly organized Civic Club, which includes in its membership many of the brightest men and women in the two cities. It is understood that the Social Science Committee, of which Dr. F. LeMoyne is chairman, will take up the question of free public baths and push the matter vigorously.

At the business meeting of the Academy of Medicine, held last Monday, a standing committee, consisting of five fellows, to be known as the Public Health Committee, was created. This committee will co-operate with the city authorities and the Civic Club in furthering sanitary and hygienic schemes.

A petition was recently presented to the Allegheny Council, signed by a large number of physicians of that city, requesting that a medical man be placed at the head of the Bureau of Health. At present this office is filled by a layman, as it is also in Pittsburg.

There are at present six large hospitals (one of which is homeopathic) in these two cities, besides several smaller ones. This number is to be increased by two new ones, St. John's, in lower Allegheny, and St. Margaret's in Pittsburg. This last named hospital was provided for by the late John Schoenberger, a wealthy ironmaster, who left \$800,000 for the purpose, stipulating in his will that the hospital should be under the control of the Episcopal Church and modelled after St. Luke's Hospital, of New York. He also bequeathed a large tract of land, upon which to erect the hospital. Plans for an up-to-date hospital on the pavilion plan, costing \$300,000, have been approved, and it is expected that work will be begun in the spring. So, if the full bequest of \$800,000 is realized, \$500,000 will be available for an endowment fund.

One sort of a hospital Pittsburg does not possess—*viz.*: one for contagious diseases. The necessity for one was strongly urged by the president of the Academy of Medicine, Dr. M. R. Ward, in his annual address.

The Allegheny County Medical Society and the Pittsburg Academy are both in flourishing condition. Dr. F. LeMoyne has been elected president of the former, and Dr. I. J. Moyer of the latter, for 1896.

The Academy of Medicine will move its quarters to the Free Dispensary Building on April 1st. Its scheme to start a library promises to be very successful. A large number of books and journals have been donated and over \$1,000 subscribed.

The commencement exercises of the medical department of the Western University of Pennsylvania will be held on the 28th of this month. Eighty-eight candidates will receive the degree in medicine.



OFFICIAL PROCEEDINGS  
OF THE  
Cleveland Medical Society

REGULAR MEETING, FEBRUARY 14, 1896

*The President, DR. COOK, in the Chair.*

The Society was called to order at 7:55 p. m. The following recommendations were made by the committee on the President's address, through the chairman, Dr. Wirt:

- 1st. That sections be formed.
- 2d. That non-resident membership be increased as much as possible.
- 3d. That the Society use its influence toward the founding of a bacteriologic laboratory.
- 4th. That a committee be appointed to provide for permanent quarters for the Society.
- 5th. That it is desirable that the State Medical Society be induced to meet in Cleveland in 1897.

DR. TUCKERMAN reported for the Committee on Legislation, the work of the Committee in behalf of the Kimmell Bill.

Report of Cases and Exhibition of Specimens

DR. I. W. BARD

*A case of Goiter*

In compliance with the request of several of the physicians of the Society, I bring before you a case that I think most of you have seen before. This boy was operated on one year ago for removal of the thyroid gland for goiter, by Dr. Allen. He had been operated on some six months prior to that time for adenoid growths. After that operation the thyroid gland took on active growth and increased very rapidly, so that an operation became necessary. It has been stated, I think first by Dr. Love, of St. Louis, that after the removal of adenoid growths other glandular hypertrophies are very apt to take on renewed growth and increase very rapidly.

There is one point to which I wish to call your particular attention. He is now a trifle over fifteen years of age. At the time he was operated on he was fourteen. When he was presented to the Society before, he was a small, undersized, stunted boy. Since his operation he has grown and developed amazingly—nearly six inches in height. This is in keeping with the expressions that have been made here by the specialists, that these glandular hypertrophies and adenoid growths do retard the growth of children. Dr. Bard also exhibited specimens of gauze bandages which he had had cut upon a paper-cutting machine at a printing office.

DR. W. E. WIRT

*Disease of the knee-joint*

I have several cases to report. I beg the indulgence of the Society for taking so much of your time this evening, but the Chairman of the Committee on Program informed me that the program was very short.

First Case.—Charlie D., eight years old, has been under my care for three years for white swelling of the knee-joint. There is no tubercular history in the family, but the child appears of scrofulous diathesis. He had a discharge from his ear when I first saw him, but that, I believe, has about healed up. He fell at the age of two years and has been lame ever since. He was advised at one time by a surgeon, now dead, that the tendons be cut and the knee straightened. February, 1893, I examined the boy and found the knee hot, painful and swollen; there was a scar on the outer aspect of the knee, said to be the result of an old discharging sinus; the knee was held flexed at an angle of 140 degrees. There was some slight motion, but this motion was very painful to the child.

The treatment consisted first in straightening the knee by means of the Billroth splint. It is a hinge splint, incorporated in plaster of Paris, reinforced posteriorly, cut through and then straightened from day to day; wedges of cork are put into the posterior slit in the plaster, and in that way by a very cheap piece of apparatus, you can straighten almost any of these knees. After straightening it I applied the Thomas knee-brace, which he is wearing now. The knee is encased in plaster of Paris. We have thus protection and fixation. I did not find it necessary to cut the tendons to straighten the knee. So we have the knee straight. It is protected by the plaster of Paris, and fixed and protected by the Thomas knee-brace.

The boy has improved right along. While the knee at that time was exceedingly sensitive, with but little motion, now we have motion in the knee without pain, and the outcome is going to be a considerable amount of motion, with probably no shortening. These children can run and play with this brace on. The foot is off the ground and there is no concussion of the knee in the act of walking. In white swelling of the joint we ordinarily do not have shortening. We sometimes have lengthening, sometimes as much as one-half inch, due to increase of blood to the part.

Second Case.—I have here a case of injury to the knee-joint, as follows: Theodore G., aged thirteen, ankylosis of the left knee. Family history negative as to tuberculosis. The boy was well up to two and one-half years ago. At that time he was hit on the external surface of the left knee with a bottle. Within a day or two the knee was hot, painful and swollen. It is said that the attending physician claimed the "water of the knee" escaped on the third day. Possibly there was not a cut clear through into the joint, but the injury caused a synovitis, and following this an increase of synovial fluid, and then a bursting of the synovial membrane, allowing the exit of this fluid, and then the infection of the joint.

The boy was sick for thirteen weeks, the knee being dressed from time to time. At the end of this time the knee was stiff, but in the straight position. Soon the knee began to draw up, that is to flex. This continued till about ten months ago. Since then the drawing up has been slight, if any. The knee was to have been resected and arrangements had been made to take him to Buffalo. If the doctor had seen the knee I do not know

whether he would have resected. But, nevertheless, all arrangements had been made to resect the joint. He was brought to me and the statement was made that there was a complete bony ankylosis. I took the boy before the Wooster class, that is about to graduate, and they all said that it was a complete case of bony ankylosis. I told them I would attempt to straighten it with the Billroth splint; that it was not bony ankylosis, but ligamentous. We will go on and straighten that knee, save the joint and get motion. Instead of the resection, followed by a shortening of four or five inches, we will have a limb of the same length as its fellow, with motion in the joint. That it is not a case of bony ankylosis is proved by the amount I have already straightened the joint by the use of the Billroth splint which he has on.

**Third Case.**—I have here a case a little different from the rest. The latter part of November this young lady fell and struck on her knee, dislocating the patella. Following this accident there was an acute synovitis. I would say that the girl had a club-foot; that she had had six operations on the foot when I first saw her two years ago. I operated and got the foot straight as you now see it. I call your attention to this to explain that the atrophy is due to the original club-foot.

I used the ordinary methods of cold application, rubber bandages and rest, but she started to walk around too soon, and we have a continuation of the inflammation, which is in a sense chronic. It has now been running on three or four months, and it may be some time before we get a cure.

One of the points to be made is that a girl fifteen years old, while she had a fall followed by inflammation, did not have the tubercular inflammation. Had she been a child five or six years old, we would probably have had the same condition as in the other case.

**Fourth Case.**—I present here a case with white swelling, with what you might call a perfect cure, Helen M., aged 13. The inflammation of the joint began at the age of three. There was no history of traumatism, but there is a family history of tuberculosis. She was first treated for rheumatism, then for white swelling, by plaster bandages. Counter-irritation, compression and fixation were used irregularly. Six months prior to my seeing this patient, resection and amputation were proposed by Denver surgeons, on the ground that the knee could not be saved. I saw her March 10th, 1893. I straightened the knee by plaster dressings, and April 5th applied the Thomas knee-brace. The final result is as you see here tonight, a perfect cure.

I wish to show you the motion that we get in the joint. There is perfect flexion and perfect extension. The knees are of exactly the same size. The inflammation is all gone; she walks without a limp, as you see.

You have here a white swelling of the knee-joint with a perfect cure obtained.

### Discussion

**DR. C. F. HOOVER:** I would like to ask Dr. Wirt the importance of extension with the Thomas splint.

**DR. L. B. TUCKERMAN:** It is a little painful to me to hear that called the Billroth splint. The Doctor tells me Billroth invented that about ten years ago. It is a modification of a splint invented by a New Haven man, and used with as much satisfaction as the Doctor's, nearly twenty years ago. I want to claim priority for our side of the water.

**DR. WIRT:** Answering Dr. Hoover's question as I understand it, in regard to extension, I would say that I have often used it, but not with great satisfaction. It is rather difficult to apply, or at least it takes up time and requires a good deal of attention, and I never could see that much was gained by it. I think that fixation and protection are the cardinal points in white swelling of the knee-joint. Of course in hip-disease extension is very important, but in white swelling of the knee it is of much less value.

In regard to this Billroth splint, they say there is nothing new under the sun, and I know that braces of this kind have been used for a long time. In fact, this slot here is a modification that we adopted in the Hospital for Ruptured and Crippled. Originally Billroth simply had the joint in the splint, but for reasons that I will try to explain, we have put in the slot. The axis of motion in the flexed position is posterior to the center of the joint. Now, as you force the leg straighter and straighter, the axis of motion is changed, and it is the intention in having this slot to allow of moving the center of motion forward, so that the center of this instrument shall correspond with the center of motion in the joint. That was a modification added in the hospital, but still we retained the old name. I think it is true in regard to a great many braces and splints, that we simply modify them and then give them different names.

### Program

**DR. J. M. INGERSOLL** read a paper on  
*Emphyema of the Accessory Cavities of the Nose*  
This paper will be found on page 154

### Discussion

**DR. WILLIAM LINCOLN:** I think the importance of these collections of pus in the accessory cavities of the nose can hardly be overrated. The investigations that have been applied to this part of our anatomy in the last few years, I think, have added considerably to our knowledge in diagnosing these important cases. A great many of our patients have been relieved after long suffering by proper treatment directed to these parts. This is very well illustrated by a case, reported by Bosworth of New York, I think in the *Medical News*, of melancholia, which came on after an attack of epidemic influenza and hay fever. The patient had been successively but not successfully treated and operated upon for a great variety of troubles. Among these was an operation for stricture of the urethra. He was castrated, and I think wore a seton in his neck for some time. Tenotomy of one or more orbital muscles was performed and later enucleation of one eye. He had dietary treatment with electricity and had tried the effect of several different climates, all without effect. His melancholia, together with all his bad symptoms, were cured by Prof. Bosworth, by remedying a deflection of the septum and operating on necrosed bone in the ethmoidal region.

In regard to the method of diagnosing these cases by placing the patient in positions which we imagine favorable to the discharge of pus, I think this must not be too much relied on, that is, in diagnosing differentially empyema of the different sinuses. A better means of diagnosis, leading to more certain conclusion, is, as Dr. Ingersoll points out, by experimental

punctures. Experimental punctures into the maxillary antrum, for instance, are attended with no bad results, and lead us to a positive diagnosis if we find pus, and if not empyema of that cavity can be positively excluded. The other cavities can be punctured, but with greater difficulty.

We must remember that there are a great many other causes for empyema of the accessory cavities, other than dental caries and chronic nasal inflammation. Tumors, malignant and non-malignant, may occur in these cavities, or in the nasal chamber, and give rise to pus in any or all of the sinuses. Inflammation of the mucous membrane of the accessory cavities is likely to be followed by formation of exostoses, because the mucous membrane in this locality acts also as periosteum. These bony outgrowths taking the form of lamellae or spicules, extend into or across the cavity and further complicate the use by retarding the outpouring of the retained purulent matter. The Doctor agrees with most authorities in mentioning caries of the teeth, as the most common cause of empyema of the antrum. It must not be forgotten, however, that caries of the teeth, whose roots project into the antrum, may in some case, be the result and not the cause of empyema of that sinus, by reason of nurosis occurring in its base floor.

In regard to treatment, I think the best method, unless we are quite sure the teeth are at fault, instead of extracting the teeth as they generally do in Germany, where the teeth are much less regarded than in this country, is that of Mikulicz, by opening from the inferior meatus of the nose. The instrument devised by Mikulicz answers very well, but I think the better method of operation is by means of the trephine propelled by electricity. This can be pushed through the thin osseous wall very easily, and establishes a considerable and permanent opening through which the cavity can be washed out.

While the floor of the antrum is below the opening made by this procedure, the evil effects of the retained pus are to be remedied by frequent and thorough cleansing, by means of the syringe.

Recent bacteriologic observations, by Thompson and Heulett, of London, have shown the nasal chamber to be very free from pus forming organisms. This fact, together with the simplicity of the Mikulicz operation, as compared with that of opening the antrum through the mouth, are to my mind sufficient reasons for giving the nasal operation the preference.

DR. H. S. STRAIGHT: The paper is a very excellent resumé of the present knowledge of the subject. There are some statements made that are not in accordance with the consensus of opinion as regards diseases of the accessory sinuses; but the more I read the more I am convinced that there is no consensus of opinion on this point.

There is one symptom that ought to be emphasized, that is unilateral discharge from the nose. To the best of my knowledge, as the Doctor has stated, the opening through the alveolar process of the jaw is the best operation for draining and washing the maxillary sinus.

There is no question that there is a great deal more trouble with the accessory sinuses than has been appreciated until within recent years. Foreigners have talked and written a good deal about the subject, and they have waked up to its importance in the east, in New York, a good deal through the labors of Dr. Myles. I have been trying to learn something about this condition for a number of years. There is no question that a great many cases of disease of the accessory sinuses go from pillar to post without diagnosis.

The frequency with which the different sinuses are affected is not settled. The great majority of observers believe that the maxillary sinus is the most often affected. I saw the opinion a day or two ago that the ethmoidal cells are more often affected. I confess I have no right to an opinion, because I have not seen cases enough. Everybody is agreed, however, that disease of the sphenoidal sinus is very rare.

As to the origin of the disease, the dentists believe in the dental origin because they probably see more cases that arise in that way. On the other hand a good many rhinologists believe that these cases are more frequently of nasal origin. The matter is not settled, the chances are that the dentists are right.

Neuralgia is a very important symptom. I recently saw a young lady who had been out of health for four years. Four years ago she had neuralgia of the right side of her face, and suffered for months without benefit from treatment. Finally she came to me with inflammation of the middle ear. A chronic suppuration of the right maxillary sinus was discovered. As to the odor, it is not appreciable to others. There is a difference between it and that of atrophic rhinitis, in which there is so much odor. In this kind of case the patient smells the odor himself and worries lest he be offensive to others.

Another important symptom is that when the patient gets up in the morning he has a good deal of discharge from his nose. When he is recumbent the maxillary sinus does not drain. There are cases, too, in which no obstruction seems to be present.

DR. L. W. CHILDS: In these experimental procedures, standing persons on their heads in order to get pus running out of the antrum, is there not danger of infection of the frontal sinus?

DR. INGERSOLL: One of the gentlemen spoke about Mikulicz operation and the trouble of sometimes keeping a permanent opening. I think as a rule there is not much trouble. I have a case where I made the Mikulicz operation about three weeks ago, and I find no trouble at all in introducing a small tube. I see the patient every day and the opening has not shown any tendency to close.

In regard to the experimental or exploratory puncture, I usually use 20% cocain, simply cocainizing the inferior meatus just under the lower turbinal, and it is almost absolutely painless. It hurts, perhaps, about as much as sticking a sharp needle into your finger. There is very little pain and if there is no pus in the antrum the opening heals up immediately and you get no bad results, but you have a positive diagnosis; and if there is pus you know it. I am very much in favor of making it. As far as I can see there is little or no objection to it.

In regard to polypi in the antrum, they do occur. I recently had the good fortune to see a necropsy in which I had made experimental puncture, found pus, and Dr. Hamann had opened the antrum. The man was in very bad condition and died of septicemias. One of the interesting things noted in washing out the antrum in this case was a symptom which might lead you to suspect polypi there. Sometimes in washing it out the fluid would flow out freely through the natural opening into the nose, and then of a sudden it would stop. Then by waiting a minute or shaking his head and syringing the solution would flow through. At the time it did not occur to me, but anything of that kind would now suggest to me the

presence of polypi in the antrum. In the necropsy we opened the antrum and found polypoid degeneration there, and a polypus pretty nearly as large as my little finger (perhaps less than half as long.) It hung from the superior and posterior wall, and was about an inch long, so that it could easily float down and stop the opening.

In regard to infecting the other cavities, I think there is little or no danger of that.

DR. T. B. WILLIAMS read a well-considered paper on typhoid fever. He spoke of the Brandt method, with which Dr. Sihler, of this city, has been so successful. This treatment requires special equipment and competent nurses. "A successful issue of a case," says Baruch, of New York, "is almost assured, if the bath treatment, according to the Brandt method, is inaugurated prior to the fifth day of the disease." The objections are the exhausting of the patient by lifting him out of bed and putting him back again, and the staff of attendants, which, in the poorer walks of life, is unavailable. The Woodbridge treatment is, no doubt, of value in the hands of Dr. Woodbridge himself, and perhaps in the hands of a few others. Its objections are that it creates a disagreeable burning sensation in the stomach, and that patients object to being troubled so often to take the medicine.

Complete rest in bed is an essential part of the treatment of the disease. The earlier the patient is put to bed the better. The sick-room should be large and airy, and if possible, should have a sunny exposure. The room should be kept scrupulously clean and well-ventilated, but without drafts.

The diet is of the greatest importance. It should be from the beginning liquid and easily digested. Milk is one of the best and most easily accessible articles of diet. In many cases it is the only food that need be given throughout the disease. From three to four pints a day is the amount ordinarily required for adults, provided it does not disagree. It should be given in small quantities every two or three hours. Care must be used not to overcrowd the stomach, as this may cause serious harm. Milk may be given plain or boiled, hot or cold, iced or peptonized, or with Vichy or lime water. Sometimes milk does not agree or becomes repugnant. In such cases buttermilk or kumyss may be useful. Broth and soups of mutton, beef, veal, oysters or chicken are often useful. White of egg is valuable given in water or with stimulants. Beef-juice, especially that prepared by the Mayell-Hopp Company, is of superior merit, and will usually stay on the stomach though everything else is rejected. I find little use for the various meat-extracts that are found on the market. The various dried-milk foods and peptonoids may be of occasional service. As a rule it is better to administer nourishment at night as well as by day. Water should be given frequently in small quantities and at short intervals. Alcoholic stimulants are seldom required within the first fortnight. Later, as the heart-action becomes weaker, they should be given. Patients above middle life usually require more stimulants. Antiseptic mouth-washes should be used freely. Of the intestinal antiseptics salol and calomel are the most important. Quinin in small repeated doses is a conservator of vital energy. Pepsin and hydrochloric acid may be given to aid digestion.

To control diarrhea nitrate of silver is useful, and for hemorrhage opium should be given without stint. The latter is sometimes called a

splint for the bowels. As the disease progresses further strychnin should be used in many cases. The coal-tar products, antipyrin, phenacetin and others, should seldom be given, and if at all, with the greatest precaution and combined with some cardiac stimulant, such as caffeine. Out of an experience of over 175 cases of typhoid, treated from the beginning to the end of the disease, I have only one death to report, and that was attributed to eating a bunch of grapes. This seems almost incredible. Due credit must, however, be given to good fortune in these cases.

The object of my paper, in conclusion, is to bring out the thought that good and even excellent results may be attained along the lines indicated above without any set line of treatment, simply by meeting the indications as they arise.

DR. L. W. BARD: I am surprised to hear an article on the treatment of typhoid-fever and no mention made of Dr. Geo. B. Wood or turpentine.

DR. P. M. FOSHAY: There are one or two things in regard to the treatment of typhoid-fever that are worth noting, in addition to what has been said. It seems to me that it is rather a figment to call the milk-diet, in the treatment of typhoid-fever, a liquid diet. It is a liquid diet so long as the food is outside the body, but it is no longer liquid after it is once in the stomach. At the same time the milk-diet is what I use myself, because it is the thing to do. I believe that broths and meat-juices are entirely safe to give and are much better food than the milk-diet; but yet, in the present state of professional and public opinion in regard to it, it is safe for the practitioner to use milk. We often see where milk disagrees with the patient; he vomits, and what is vomited is large hard curds. I believe myself beef-steak would be just as well digested as milk, if well masticated.

Dr. Williams said he used liquid peptonoids. So far as I know there is no nourishment in liquid peptonoids. These preparations have been analyzed with the result of finding they contain no peptones. Peptonoids do not exist.

Among the antiseptics, which I suppose all practitioners use, the one I have liked best is salicylate of bismuth, but of late I have been using benzozol with very satisfactory result.

DR. I. W. BARD: This is a subject that to the general practitioner is of a great deal of interest, probably more so than almost any other subject that could be introduced in this Society.

In regard to foods, in my practice I very seldom give milk alone. Milk, especially if taken in large quantities, is very apt to produce large, heavy curds, which are not digested in the stomach. This may be prevented by diluting the milk with water. The physician must always adapt himself to circumstances and to his patient, and a great many of our patients come from the poorer classes. I have found that to a great many of my patients I can give a piece of beef-steak broiled, and tell them not to swallow it, but to extract all the juice from it, and they in that way get a great deal of nourishment.

There is one thing the paper read before us failed to note at all, that is, the disposal of the feces; one of the most important points in avoiding infection.

There is yet another feature in the treatment which was not mentioned, and that is the injections of water. We have had the bath treatment of the three different varieties; sponging, packing and the full bath. The



injections of water I have followed out in my treatment for the past couple of years, and I like it, and think anyone who will use it will find it good. Large rectal injections of water are given almost cold. If the patient's fever is high, the addition of a little carbolic acid to the water will be of great benefit in reducing the temperature. By the use of it you make an internal bath which flushes out the intestine and carries away the germs and bacilli which are infesting the lower part of the bowel, thereby removing much poisonous material from the patient. And it is surprising how large an injection some of these patients will bear. I have also found it of very great benefit in patients who were having involuntary discharges from the bowel. By giving a large injection and using a bed-pan immediately afterward you anticipate the movement of the bowels, and can save any soiling of the bed.

In internal treatment I have found carbonate of guaiacol useful, given in five grain capsules every four hours. If the temperature is high, add to each dose  $2\frac{1}{2}$  grains phenacetin. Of late I have been using lactophenin, and like it for more reasons than one. It not only reduces temperature but acts as a hypnotic when the patient is restless or delirious. I have found it of decided benefit.

DR. R. M. WOODWARD: I would like to say a word on this subject. I do not like to tell fish-stories, but I have the records to show for it. I have had in hospital thirty-five consecutive cases without a death. Twelve cases have occurred in Cleveland. They have been examined from time to time by very distinguished gentlemen, and they have been used in the clinical lectures of Dr. Lowman. They are typhoid-fever cases.

In regard to the treatment, my main treatment is milk. I believe in milk; and rather than give four pints in twenty-four hours, I try to give nine. I founded my treatment upon the physiologic digestion of milk, and in order to get the proper amount of the four kinds of food you have to give nine pints of milk. A sick man will digest nine pints of milk under ordinary circumstances. The nurse keeps a table, and every time she gives a tumbler of milk she marks it down. These tables are kept and they will average eight pints of milk in twenty-four hours. I was asked by Dr. Humiston if the milk did not fail to digest and cause tympanites. On the contrary, my cases are peculiar in having a very flat abdomen.

In regard to the coagulation of milk, it is true contact with the gastric juice will curdle it to some extent, but it is very readily redissolved when it reaches the pancreatic and other juices of the intestine; and we know that in the majority of cases the stools in typhoid-fever are liquid; and I believe that when these curds are found in the stools they are not the result of the milk undigested but are reformed after it has passed to the diseased portion of the bowel.

I do not give cathartics. When the bowels become constipated I rely upon enemata. The cathartic causes a peristaltic movement of the bowel. The peristalsis is quite a powerful contraction of the bowel, and in my opinion it takes very little to force the contents of that bowel through the ulcerated portion into the peritoneal cavity. I rely almost entirely upon rectal injections. I have not, in the nine and a half years I have been in the Marine Hospital service, signed a certificate of death from typhoid-fever.

The distinguished Dr. Woodbridge was invited to my hospital to see three cases. He verified the diagnosis. One case he criticised because the

man was sick on the seventeenth day. I do not like to criticise the doctor in his absence. I noticed in an article that he claimed almost infallibility in the matter of diagnosing typhoid-fever; and moreover in cases which were doubtful, he recommended his treatment whether typhoid-fever or not and it would cure the case. There was another case we had been expecting to die for three or four days. My friend Dr. Hoover had examined this case very thoroughly and had given up the diagnosis as had everyone else. Dr. Howard came to the hospital and made cultures from the blood and gave up the diagnosis. I asked Dr. Woodbridge if he would diagnose the case. He examined him thoroughly, and, after hesitating, said he would not like to risk his reputation on the diagnosis. I asked him if his treatment would cure the case, and he said he would not like to risk his reputation on it. We continued the treatment we had been using from the first, and for some unaccountable reason the boy got well. If it was a case of typhoid-fever it makes thirty-six, if not thirty-five.

**THE PRESIDENT:** It is now after the hour that we must close, and we will be compelled to ask that the discussion close here, save for Dr. Williams' reply.

**DR. WILLIAMS:** I am very glad to have an opportunity to explain this paper. I wrote a little at it last week in a very hasty manner. This week I have been laid up with—I don't know what it was—grip, perhaps.

Dr. Bard spoke of the old turpentine remedy. Dr. Wood's turpentine treatment is certainly one of the old reliables. Had I given you all of the methods—had I given you this treatment, or that, or the other, I would not have got through tonight. I intended to give you a short paper containing a few points. I intended to emphasize the importance of bathing. I intended to mention the turpentine treatment. I spoke about salol. I simply gave that as a typical remedy, and a very good one. I saw typhoid-fever when I did not know anything about salol. The point which I wished to emphasize was simply this: That whatever you see to do, so to speak, do. I can not tell you what to do; you can not tell me what to do in a case of typhoid-fever. I may do so and so today and tomorrow I may have occasion to modify that treatment.

I spoke of the old friend, calomel, and I would put great stress upon that old remedy, nitrate of silver. I change my treatment. And so, as I said before, quoting from our old friend, Dr. Thayer, "Fulfill indications."

**DR. WOODWARD:** In regard to the use of calomel, I intended to speak of one case of the thirty-five, in which I had perforation. It was a case in which the interne gave calomel. I do not say it was due to the calomel, but it is worthy of thought.

**DR. WILLIAMS:** One point more in regard to that. I say there are comparatively few cases in my hands that do not get a little calomel somewhere. I perhaps overestimated that when I gave the formula. Perhaps the next day I would not give it. It is a streak of luck, so to speak, that is all. I aim to be somewhat modest in my assertions. But I have had a wonderful experience if it has been typhoid-fever.

REGULAR MEETING, FEB. 28th, 1896

*The President, DR. COOK, in the Chair*

Society called to order at 7:50 P. M.

The minutes of the last meeting were read and approved.

### Unfinished Business

Amendments were passed to secure a more uniform representation of standing committees in the council and discontinuance of the office of Librarian. An amendment to authorize the formation of sections was tabled after some discussion.

Dr. Foshay was unanimously nominated as the choice of the Society for member of the State Board of Registration and Examination.

### Report of Cases and Exhibition of Specimens

DR. C. A. HAMANN: I have a specimen here that may be of interest in connection with the essay that we are to hear this evening. It was taken from a patient, a young male adult, who sustained his injury by diving into shallow water. When he was removed from the water he was found to be paralyzed. He lived for some three months, dying of exhaustion and progressive sepsis, and the specimen here shown was procured.

From the symptoms present during life we located the lesion in the neighborhood of the fifth cervical vertebra. When you look at the specimen you will see that the laminae of the fifth and sixth vertebrae are fractured. The theca of the cord has been opened and one sees that the cord has been crushed. On viewing the anterior aspect it seems that the body of the sixth cervical vertebra is somewhat comminuted. Absolutely no calus has been thrown out. There is degeneration of the columns of Goll and Burdach.

DR. C. J. ALDRICH: Through the courtesy of Dr. Friedman I examined the former owner of these damaged vertebrae, which Dr. Hamann presents this evening, some eight or ten days after the injury.

All motion and sensation were destroyed below the fifth segment. There was no evidence of the injury but the paralysis, no deformity, crepitus or embarrassed respiration.

Some little lapping over the sensory areas was shown by the presence of sensation along the outer and dorsal surface of the meta-carpal regions of the thumbs. Otherwise the lines of anesthesia were markedly symmetrical and very distinct. The right biceps was the only muscle below the shoulder line that was not totally paralyzed.

About eighteen days after the injury a line of hyperesthesia developed at the upper border of the anesthetic line, and was marked by great sensitiveness to all impressions. Some disturbances of temperature occurred in the second week; one day it oscillated between 2° below and 5° above normal.

The case is remarkable on account of the depth of water into which he dived, being 4½ to 5½ feet deep. This depth would seem sufficient to have mitigated the force of the blow, which these fractured laminae testify as being severe. Also, he was sure that he did not entirely lose consciousness, notwithstanding that when he struck the bottom of the lake he became immediately paralyzed below the neck.

One thing strikes me as very peculiar. You will observe both in the very remarkable case exhibited by Dr. Kaestlen, and in the pictures shown by Dr. Wirt, that the cases which have recovered present much deformity, which is evidently not alone due to callus, while the fatal ones present little or no deformity or physical evidences of fracture or dislocation outside of the effect on the spinal cord.

DR. L. B. TUCKERMAN

*Suppurative Appendicitis in the Sac of a Right Inguinal Hernia*

The history of this specimen is as follows: On the 7th of October last, a farmer, 73 years of age, somewhat spare, but hale and wiry withal, was unloading corn-fodder from his wagon in the barn. Suddenly he was attacked with severe pain and fainted, and was found in that condition by his wife. For years he had had a small hernia in the right groin, but as it seldom bothered him he had never worn a truss. Some six weeks before this, however, while chopping, he had fainted in a sudden attack of pain, but recovered shortly, and so thought nothing further of it. He was not so fortunate this time. Persistent vomiting followed and obstinate constipation, accompanied by spasmodic pains. He would allow no doctor called, and this went on for a week, the vomiting, meanwhile, becoming fecal in odor. At this juncture a married daughter came home, and recognizing the gravity of the case, sent for a physician at once. He pronounced it stomach trouble, and prescribed a physic. In three days the bowels were moved and the vomiting ceased, whereat the attending physician dismissed the case.

The bowels continued to move regularly till November 1st, on which date there occurred an unusually large passage—the family described it as “a vessel-full.”

From the time when he first took the physic he began to suffer excruciating pains in the groin, but notwithstanding, he kept about and did his own chores. Meantime another physician was called, who tried to fit a truss, but this so aggravated the pain that the attempt was abandoned.

On the 30th of October the groin began to swell rapidly and grew red and angry looking. I was called to see the case on the evening of November 4th. His bowels had not moved for three days, but the abdomen was not tympanitic; pulse 84, regular and of fair force and volume; temperature 100; tongue heavily coated. In the right inguinal region and extending from the base of the scrotum to the anterior spine of the ilium, and upon the thigh as low as the saphenous opening and to an equal distance above Poupart's ligament, was a tense, brawny swelling, livid in color, perforated on the top by two small openings, from which there oozed a thin, foul-smelling pus, with a decided fecal odor. These openings had appeared within the last six hours.

A free incision was at once made along the line of Poupart's ligament and carried through the gangrenous tissue, which seemed to be over an inch in thickness and thoroughly infiltrated with pus. Free drainage being thus provided for, hot applications were made for forty-eight hours, by which time the line of demarkation between slough and healthy tissue had become fairly well established. The slough, consisting of subcutaneous cellular tissue, hernial sac and omentum was then clipped out with scissors, and

at the bottom of the large cavity and projecting through the inguinal ring lay curled the specimen which is here shown you.

The distal extremity, which, as you can easily see, is perforated and eroded, was turned toward the median line, and between the base of the appendix and the median line was a free perforation into the bowel, a portion of the intestinal wall, probably of the *caput coli*, having been part of the slough.

In spite of a good deal of leakage through the fistula, the bowels moved freely *per anum*, and by frequent cleansing, careful limitation of diet, and the persistent application of as much pressure to the opening as the patient would bear, by means of a flannel bandage and compress, an occasional stimulation with lunar caustic, the opening closed without operation, during the early part of this month.

I report this case because appendicitis occurring in a hernial sac is not overly common; and also because it illustrates a clinical fact which I have heretofore urged before this Society, viz: that when the colon is impacted and the appendix is irritated, and its proximal end is dilated by reason of such impaction, cathartics are likely to precipitate an acute inflammatory attack. Nothing can be more illogical than the advice so often and so flipantly given by the operative specialist, "Give salts freely, and if the symptoms get worse, operate."

You will observe in this case, as I have often observed in other cases, the severe local symptoms dated from the exhibition of the cathartic. No line of treatment can be better calculated to further the practice of operative surgery, by directly provoking those very symptoms which urgently call for operative interference. Because free catharsis with salines is an efficient prophylactic against traumatic peritonitis, it by no means follows that it is the proper remedy to exhibit when the appendix is already irritated and the colon already over-distended and blocked with impacted feces. Instead of still further ballooning a gut in such a condition with the liquid contents of the small intestine, forcing those contents under pressure into the open mouth of the already irritated appendix, rational treatment calls for the quieting of peristalsis and the alleviation of pain with opium; for mercury pushed to its full constitutional effect to forestall serous inflammation, and after the pain is quiet, and after the constitutional effects of the mercury become manifest, then is the time to attack the impaction from below with plain or saline enemas.

Another thing which was observed in this case bears upon the therapeutic value of sugar-coated tablets. For a short time this patient was given sugar-coated tablets of quinin, as a tonic. As regularly as they were given they would pop out of the fistula three or four hours afterwards, with the coating still undissolved.

DR. M. ROSENWASSER: I did not intend to discuss this question, but I know that Dr. Tuckerman has repeatedly criticised the surgical treatment of cases of appendicitis. I wonder if this appendix could have been cured by calomel.

I do not understand the theory of Dr. Tuckerman that, when the appendix is irritated and its proximal end is wide open, a cathartic will precipitate an inflammatory attack. With the appendix wide open, flushing will merely clean it. I understand that it is a good thing not to give cathartics after operation, in order to prevent peristalsis. I agree with him in this practice, but not in his theory.

DR. O. B. CAMPBELL: I was just going to say I would like to have explained the theory of that sugar-coated quinin tablet not dissolving.

DR. D. S. HANSON: I can hardly see wherein an appendix with a wide-open proximal end, is doing any harm.

DR. TUCKERMAN: I am not explaining what Dr. Campbell asked. I only stated a fact. I have observed the same result when I myself was lying ill. It was a particularly fine pill, which the druggist guaranteed would dissolve. And they did not come out of a fistula either. That is the objection to depending upon coated medicine. We find in certain conditions of the digestive tract they do not dissolve.

Of course we all make working hypotheses for our practice. We may be wrong, but yet it seems to me you give cathartics producing a free flow of liquid feces from above and the first thing you do is to drive the already impacted feces up into the angle of the colon under the liver, and the result is a ballooning of the *caput coli* itself, and that ballooning and pressure force the mouth of the appendix more or less wide open, and if there is weakness of the wall of the appendix anywhere or any tendency toward perforation, the tendency is to push that fluid through and make an actual perforation.

I believe there is an appendiceal colic, which is not appendicitis; and if you follow the rational treatment of rest and quieting peristalsis, with treatment of the constitution, they will get along, whereas by actively treating it with cathartics you will bring about a condition where operation is absolutely necessary.

DR. W. E. WIRT

*Two cases of Lateral Curvature of the Spine*

I exhibit here two cases of lateral curvature of the spine., because the two papers of the evening touch upon deformity of the spine, and I think these cases will be somewhat illustrative.

I have here this child, twelve years old, that as you will see by the markings upon the back, has a marked lateral curvature. This child gives a history of having fallen out of a cradle, or something of the kind, when quite small, and very soon after that developed lateral curvature.

On Monday I took a cast for a corset, similar to this, of a child that is 20 months old, that also has a lateral curvature. I speak of it to show how early this curvature may develop.

I have here (Case II.), worn by a girl having lateral curvature, a felt corset, which I use in these cases. I obtain this corset by first suspending the child, which will very much lessen the deformity, and in that position I put on a plaster of Paris cast. As soon as hardened I cut off the plaster of Paris and remove it from the patient. From this jacket I make a plaster mold, which I afterwards modify in shape, and over which I make the felt corset, reinforced by light steel springs. By the suspension you see we get a partial correction of the deformity. By modifying the mold, *i. e.*, by shaving down the plaster at the point of deformity and by building up on the hollow side we get a pressure from the corset directly on the deformity. On the hollowed side we leave space for filling in of the chest. The shoulders are held back by these straps attached to the corset.

This is only one of several things that I do. For treatment we have the use of the corset; the building up the shoe to correct the deformity by throwing the curve in the opposite direction; the building up the hip to

reverse the curve; the use of a cap on the head attached to straps on each side of the corset, also to reverse the curve; the use of gymnastics; the use of the sleeping cradle, and one or two other measures.

This being a clinical case, I have not been able to carry out these measures from a lack of funds. The curvature in this girl as shown is not great, that is, as compared with what it was. The curvature is not one-half as great as it was when we started in with the case. Of course the child does not wear the corset all the time. She wears the corset in the day time when she is not exercising and not carrying out other instructions. Three or four times a day I have these patients suspend themselves; and then at night they take off the corset and sleep in the cradle, an apparatus that reverses the curve.

In the discussion of Dr. Sherman's paper, in which I hope to have the pleasure of taking part, I will show upon the screen, if I may be allowed, certain pictures to show what can be done in the way of correcting these deformities by posturing.

### Program

DR. S. E. KAESTLEN

*"Fracture of the Cervical Vertebrae with Recovery," with presentation of case.*

This paper appears on page 141 of this number of the JOURNAL.

### Discussion

DR. W. E. WIRT: The writer of the paper, the doctor who has been treating this case, has asked me to discuss it. I take considerable interest in the subject, especially as I have seen a few of these cases myself. I will relate one case—a classmate of mine in the U. S. Naval Academy, while in the gymnasium endeavored to do the "cut-off," missed his hold and fell about one foot. There were double cushions under him, and yet he fractured one of the cervical vertebrae. He lived about an hour. It is a very remarkable case in which we have recovery at all. Recovery is very, very rare.

The Doctor has gone over the paralysis and all the resulting symptoms. He asked me to discuss the curvature and what could be done for the neck. The curvature might later be corrected. The cap previously described could be used to draw the head over from day to day. By passive exercise you might increase the motion of the head.

I took the trouble to have some lantern slides made of several cases that are reported in the *New York Medical Record*, October 28th, 1893, by Dr. Manley. (The slides referred to were here presented.)

DR. J. B. MAGEE: I saw a fracture of the 6th cervical vertebra. In that case there was no paralysis of respiration. The boy is now quite a young man.

DR. C. J. ALDRICH: It occurs to me, while speaking of temperature, that in this case one day there was a temperature of two degrees below normal, and the next day a temperature of 104½.

DR. G. S. SMITH: In the practice of the Rhode Island Hospital during the last year I have seen three cases of fracture of the spine.

The first was diagnosticated at the fourth cervical vertebra. A teamster had fallen off his team. We placed him in extension, lifting the head of the bed and putting on about five pounds. He died about six hours later with a temperature of 107.

The second case was a child of twelve, with fracture of the second dorsal. We treated him in the same manner and he is living at present and gradually improving.

The third case was similar to the first, dying within two days.

DR. C. B. PARKER: From what has been said we may conclude that occasionally a fracture of the cervical vertebrae will recover. Of course none of the gentlemen would intend us to imagine that in any of these cases of recovery the cord was more than simply compressed. It can not be destroyed or recovery would be impossible.

I never have seen a case of fracture in the cervical region, although in my hospital practice I have had the misfortune to treat a good many cases of fracture of the spine. I have never had a recovery.

I had a man die the other day from fracture of the spine in the lower dorsal region, who lived about 4 or 4½ months. There was complete loss of motion and sensation below injury, and loss of power in all the sphincters and the progressive changes that follow complete fracture, but he lived a longer time than usual.

I have tried various methods of treatment. I have tried quite a number of times cutting down and making an attempt to remove depressed fragments. None of these cases ever recovered. It is a very distressing operation to perform, and always under very distressing circumstances. I have once been rewarded by finding a very large blood-clot pressing on the cord, which I was able to completely remove and with temporary improvement in the symptoms. The patient afterwards succumbed to an infection through the bladder and kidneys.

I have rather gone back to the idea that extension is generally the best method of treatment. I incline to holding the trunk, making the extension from the arms if the fracture is below the cervical region; but I have not been able to report a recovery. I do not know if any gentleman present has ever had a recovery from fracture of the spine below the cervical region.

DR. G. W. CRILE: At the City Hospital is a case, I think, of fracture of the lower dorsal or upper lumbar, the little boy, Willie, who goes about on crutches, with the lower extremities paralyzed. I am not quite sure whether it was a case of fracture or dislocation. I happened to be on duty and received the case. I think the accident was caused by a heavy weight falling on his back. I was not able at that time to make the diagnosis between fracture and dislocation. They told me today that he was from time to time getting a little more able to get about.

DR. TUCKERMAN: There is a man who keeps a saloon over on Pearl street, near Clark Avenue transfer, who, some ten years ago sustained a fracture of the lumbar region of the spine. He was treated by extension. He has almost complete paralysis of the lower limbs. He had almost complete anesthesia, but this partially recovered. In the course of two or three years after he was injured, I found him exciting motions in his toes by sticking pins in his thighs along the line of the sciatic nerve.

DR. ALDRICH: There is a peculiar thing in connection with these cases. It seems the cases that recover have extensive deformity. On the



other hand the cases that prove fatal within a few weeks have almost no deformity, and it is almost impossible to find any lesion. In this case here (referring to the specimen presented by Dr. Hamann), you could not find any deformity at all, nor could you feel any crepitus.

DR. KAESTLEN, (closing discussion): I do not know that I have much to say further. I forgot to mention that the boy complains of feeling rather warm in a cool room. His temperature is not up, but the sensation is. As to the position, it was not a matter of choice with us what we should do, but what we were compelled to, from the numerous fractures, especially a fracture of the thigh.

No one has claimed that the cord was lacerated at all, simply compressed; and we attribute the result we have had with the boy to his luck, or my being present, and the mere fact that there was no laceration of the cord.

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#### REGULAR MEETING, MARCH 13th, 1896

*The President, DR. COOK, in the chair*

Meeting called to order at 8 o'clock, Dr. Harold T. Clapp acting Secretary, owing to absence of Dr. Clark.

The minutes of the last meeting were read and approved.

#### Report of Cases and Exhibition of Specimens

DR. WILLIAM LINCOLN: The case I here bring before the Society, one of intranasal tumor, is of interest on account of the probable malignancy of the growth, and also on account of the rarity of these tumors occurring primarily in the nasal chambers.

This boy, aged 18, presented himself at the Dispensary about two months ago complaining of complete stenosis of the left side of his nose. Examination revealed a tumor that completely filled up this nostril, and he gave a history of having been in that condition for about fifteen or eighteen months. A probe was passed into the nose to see whether a snare could be passed around the tumor. This was found to be impossible. A piece was then removed by means of the cold snare, for microscopic examination. The boy presented himself again in a few days with his health very much impaired. He was rapidly getting worse and had high fever. A great deal of pus was discharging from the left nostril. Microscopic examination seemed to indicate the sarcomatous nature of the growth. He was, therefore, advised to have the growth removed as soon and as thoroughly as possible. It was determined, on account of the hemorrhage which would result from the necessary breaking up of the adhesions binding the growth to the walls of the nostril, not to attempt its removal piecemeal, as is sometimes advised, but by laying the nose over on the cheek to make it possible to remove the tumor quickly and entirely. This was done three weeks ago. The so-called Brun's operation was performed, but modified, so that, instead of cutting through the nose on the affected side, the nose was sawed through

at the bridge, separated from the face on the non-affected side and turned over by means of strong forceps upon the left cheek. This was done on account of the great amount of pus in the left nostril, which it was feared would, after the operation, infiltrate between the edges of the wound and prevent proper healing.

The result proved the wisdom of this modification, as the wound healed very satisfactorily and in excellent apposition, except where the pus leaked through at the upper part of the left nostril during the 48 hours the packing was in the nose. Here the wound is healing more slowly and by granulation. With the increased room secured by this operation the tumor was quickly and easily separated from the sides of the nostril and snared off at the base of its pedicle. This site was then thoroughly curetted and burned. The free hemorrhage was checked by plugging the nose anteriorly and posteriorly, and the nose stitched back in place.

The boy has made quite a good recovery, and is now a good deal more comfortable than he was before. There is within the last few days a slight recurrence of purulent discharge from the nose. Whether this comes from a very early return of malignant growth, or from empyema of some of the accessory cavities, I have not determined, because I have not been able to examine him carefully.

DR. H. S. STRAIGHT: I take it this is to be considered a sarcoma of the nose. Has a microscopic examination been made?

DR. LINCOLN: Yes. While first it seemed to indicate sarcoma, Dr. Howard has not been able to say.

DR. STRAIGHT: This is a case of very great interest. Sarcoma of the nose occurs very rarely. I remember having seen one case. A patient came one day to the John Huntington Dispensary, who had a growth on one side of the nose, completely filling the meatus. I touched it lightly with a probe, whereupon he had such a furious hemorrhage that I was compelled to pack the nose. Two days later he returned. On removal of the packing the hemorrhage recurred and the meatus was again plugged with antiseptic gauze. At this visit the patient's wife was informed as to the probable nature of the growth. The patient did not make another visit. The chances are this was a sarcoma. Of course the microscopic examination ought to settle it. But in the examination of the growths from the upper air-passages it is difficult to determine the character of the growth.

The location from which the tissue examined is taken must be considered. If slides are prepared from a central portion of the growth a fair estimate of its character can be arrived at. If the slides are prepared from a rapidly growing portion of the growth, it may show all the characteristics of a sarcomatous growth, although fibrous in character.

The cures reported after removal of sarcomatous growths of the upper air-passages, must be accepted with "much salt," as the chances are that many such growths were fibromata, if the reported cures are permanent.

DR. J. M. INGERSOLL: I think the doctor is to be congratulated on this case. I have had the privilege of seeing the case several times. The result is very good. The condition of the patient, compared with what it was when I saw him first, is remarkably improved.

In regard to malignant growths in the nose, I had an opportunity of seeing a woman who reported to me only twice, with the history of a slow-growing tumor in the nose, which almost completely occluded the left side

of the nose. On touching the growth with the probe, the hemorrhage was quite severe, but never enough to be at all dangerous. The second time she came I removed a piece, and Dr. Thomas kindly examined it for me. I think there is no doubt that it was carcinoma. I told the patient that an operation should be performed immediately, but she has not returned.

DR. W. T. HOWARD: I have been much interested in Dr. Lincoln's case. He showed us this afternoon sections made from various portions of the growth. In these sections there is nothing suggestive of sarcoma. It is made up of a fibrous tissue, in some places very rich in cells; it is very vascular, especially at its base, where the blood-vessels are numerous and large. It is covered with a single layer of columnar epithelial cells, which are in many places flattened out by pressure; in others the mucous membrane is absent, and there is considerable inflammatory reaction, with dilatation of the blood-vessels and leucocytic infiltration. Cultures made from the affected side before operation showed the pneumo-coccus in pure culture. This is to be looked upon, of course, as an accidental infection, and has nothing to do with the etiology of the growth. The tumor is, judging from the sections I have seen, a rapidly growing fibroma. As Dr. Lincoln has said, it is a pedunculated growth. Polypoid fibromas of this portion of the nose are not, I believe, common.

DR. J. H. LOWMAN: One would ordinarily operate on the affected side, but with so much purulent matter one can see, as an after-thought, that the doctor is to be congratulated in getting out of it in the way he did.

#### DR. R. E. SKEEL

##### *Case of Tuberculosis of the Ovaries*

I have here a little specimen, which is not of so much interest in itself as it is because it illustrates our inability to diagnose abdominal affections before operation. The patient was a foreigner. She had been married six months. A few months after marriage she began to complain of a leucorrheal discharge. Within a month after that time I examined her and found a large mass on one side of her pelvis. She came from out of the city, and I sent her back with instructions what to do. Upon her return I found the tumor larger than ever, and concluded it was a case of pyosalpinx. After I had the specimen removed, I found it to be a very thick-walled cyst, very hard and containing a cheesy deposit. On the other side the ovary and the fallopian tube were adherent. They were both removed, and, owing to the free oozing, I was obliged to use the gauze tampon.

These are probably tubercular ovaries. They have not been examined microscopically, but will be as soon as I can get around to it.

#### Program

##### POSTPONED DISCUSSION OF PAPER.

##### *Our Public Schools*

Read by DR. H. G. SHERMAN, at the regular meeting of February 28th.

DR. W. E. WIRT: It was my privilege to accompany the author of this paper on a visit to the schools. I saw many things that were utterly new to me. On entering the High School building the first special sense that was

offended was that of smell. The principles of ventilation were very poorly carried out. The next sense offended was that of sight. The building is imperfectly lighted by gas. I asked quite a number of prominent citizens if they knew that artificial light was used in the middle of the day. They declared they did not. In the room I visited, holding 40 or 50 pupils, four gas-jets supplied the artificial light. I found it difficult in certain parts of the room to read the print of some of the text-books. My eyes would not have stood the strain more than five minutes. My camera, by which I attempted to photograph the room, is what is called "instantaneous." I made an exposure of fifteen seconds and got only an outline of one or two pupils nearest the window.

Pupils were sitting in positions anything but erect. They were bent over and twisted upon their seats. This was due to the chairs. The children's feet often do not touch the floor, circulation is cut off and they have cramps. This bending over in the seat and the twisted position encroach upon the viscera, interfere with the circulation and with the activity of the brain. Furthermore, we see as a result of this bending curvatures of the spine, and I have made a number of plates from children of the schools which I would like to present to the Society. (Dr. Wirt here presented a number of views illustrating spinal curvatures.)

DR. A. R. BAKER: I would not say anything to criticise this admirable paper of Dr. Sherman's, because it calls attention to an important subject. I would not say anything in extenuation of the carelessness of the school authorities who do not supply proper school buildings. We can not charge all the near-sightedness in our schools to defective light. While Dr. Sherman has quoted what the authorities say, I do not believe the authorities and the books are to be supported in all these assertions. Because we have found an increasing percentage in the schools from the lower to the higher grades, it does not prove that because they went to school they became near-sighted. The fact of the matter is this: The near-sighted child gets more pleasure from its books than the child who has normal sight. And so we have a larger percentage of near-sighted children in the higher grades.

About ten or fifteen years ago I made some investigations on this point. I examined a thousand children in country schools where they went to school three months a year, in counties where they had nothing to read but possibly the *Clarion Democrat*, and I was surprised to find so few children near-sighted. I have examined children in other schools and have found the most severe cases of myopia among the lowest classes of foreigners that can not read.

In the discussion of this subject Dr. Risley made the following statement: "These results demonstrate the fact that the bad hygienic environments of the schools are not solely responsible, but that the chief cause is the large percentage of congenitally faulty eyes."

If these congenitally defective eyes were excluded we would soon hear the last of progressive percentages of myopia in schools. It is a terrible thing for a man, who has spent a large part of his life in preparing himself for some occupation, to become blind from progressive myopia.

Just one other word, with regard to what is said about our defective seat. I have been into our schools considerable and believe we have the most modern seat and the best that can be provided. A few years ago I went into one of these rooms and found the children all sitting up straight.

The teacher was saying: "Johnny, straighten up;" "Mary, straighten up that slate;" "Tom, put down that slate." And there they were trying to write in that position. Children learn by the ear and not by the eye. Give them more work with the ear and less with the eye.

**DR. L. B. TUCKERMAN:** It is a good thing sometimes to forget we are physicians and get on the higher plane of citizenship. You will notice that in the products of Cleveland education which Dr. Wirt has shown us on the board, all the spines curve the same way. And I want to make the assertion that the curvatures are made by the written work demanded of these children in the schools. If this Medical Society were set down at a desk and compelled to take a hair-line pen and follow a copper-plate copy as long as these children have to do it, there would not be a back in this assemblage that would not ache in three-quarters of an hour. There is no sense, there is no philosophy, there is no reason, there is no anything in the amount of written work that is demanded of these children. My child has come home from school compelled to copy over a spelling exercise five, six and seven times, and worse every time as it ought to be, because when the nerves are tired it ought to get worse. Writer's cramp is artificially produced by the attempt to push those children beyond the power of endurance. We are spending most of the time at home correcting what is done in a few hours at school. A sharpened slate-pencil should not be allowed in the school, nor anything finer than a stub pen, or an unsharpened lead pencil. This attempt to make ungrown nerves, ungrown muscles, cartilaginous bones do work that would tire a lithographer, is folly, such as was never conceived outside of a 19th century pedagogue's brain. There is another thing, and that is the nervous tension they get up, the fear of not doing well. It reflects on the eye, on the spine and everywhere.

**DR. H. J. HERRICK** suggested that as Professor Jones was present, the Society would be glad to have his views on the question.

**PROFESSOR JONES:** I much prefer to be a listener in this discussion, but since I have been allowed the courtesy of speaking I will say a few words. Modern life is rather a complex affair, and while I am willing to admit that a very large portion of the life of the youth is properly spent in school, I would be very slow, indeed, to admit that either all the good that comes to the young person flows out of school, or that all the evils that come to him are directly chargeable to the school.

I heard from Dr. Coulter, a famous botanist, a few days ago. He says no microscope has ever been invented of sufficient power to show a single root-cell in a seed; and yet, he said, that when the seed is planted the very first cell that grows from one end of that germ is in structure a root-cell, and that it points into the ground, toward the darkness; and that the very first cell that grows from the other end of that germ is in structure a stem-cell, and that its tendency is toward the light. While there is no root-cell in the seed, the tendency to produce a root-cell is there. If there is ever to be a period of development from which all these come, it must be at a time of general development of such plants.

The reason you find so large a ratio of development of diseases of the eye and curvature of the spine during the school age, is because the school age is the time of general development and all the tendencies of life are bound to come out in these years.

I was especially interested in the list of cases of curvature of the spine, so well shown by Dr. Wirt, and was peculiarly interested in the statements with reference to those cases. You observed, as Dr. Tuckerman said, that the curvatures were all of one kind. You may have observed that nearly all the cases shown were those of girls, and may remember the statement of Dr. Wirt, that while boys and girls are subject to exactly the same conditions during school hours, there are nine times as many cases of curvature of the spine among girls as boys. He might add that the conditions out of school are totally different; the condition of girls leads directly to the emphasizing of these curvatures of the spine, which he so beautifully displayed on the screen.

I should say that there are many school-houses in this city that are very ill-adapted to their purpose. Many of them were built when the conditions of good school-houses were not so well understood as now. I am sure the buildings that have been erected in the last few years will not be found to have these defects in so large a degree. Dr. Sherman, in his paper, is careful to state that in one of the rooms where he found so many defects of the eyes, the room was well lighted.

The Central High School is not well ventilated. I am sure the Director of the Schools has made all the efforts possible under the circumstances, but the building was put up without any system of ventilation. In the newer buildings both light and ventilation will be found very much better.

I wish to add, however, that the school authorities will be exceedingly thankful for all the assistance it is possible for them to obtain, especially from such an intelligent body of men as the Cleveland Medical Society. I have thought that if this Society, joining with any other forces or persons who wish to assist in such matters, would do two things for us, it might be of very great assistance.

The first is that there might be a general agreement, as I think there is among scientific people, upon certain eye-tests of such simple form that the teachers in our school-rooms might occasionally make them, so that they would be able to advise with parents.

A teacher of a first-year school said to me, that of the 55 pupils in her room, five were, at their entrance, afflicted with very severe forms of some of the commoner diseases of the eye. This lady has taught many years, is intelligent, and understands how to make these tests. These five cases were, through her efforts, sent to oculists, and appropriate means of relief were given. Of these five, three were marked cases of near-sightedness, in children of six years who had never before been near a kindergarten or school. In a large number of these cases the children came out of homes that are not so well lighted or ventilated as school-houses.

In the case of my own little child, I have great trouble to keep her from reading in the twilight hour. She is disposed to read right through that period, sitting first by the window, afterwards removing to the grate fire, if she has no better light.

A very large number of these serious conditions grow right out of the homes of Cleveland. I noticed that the gentlemen all spoke of these as Cleveland schools. The pupils are in Cleveland schools chiefly because they are children of Cleveland homes.

It is quite a problem to know how to get the best conditions out of the schoolrooms as they are in the city. One side is well lighted, the second

side partially lighted. If a good committee, including citizens, oculists and physicians, could look at such rooms, study them from all points of view, apply the well-known rules in such cases, we should find exactly how best to use the conditions which are now at hand. I am sure you will find the school authorities always ready to join hands with all good citizens in this work.

DR. A. PÆSKIND: Studying the subject carefully, we find that it is not always the school structure, nor the school furniture that gives all these defects. There is a mental state connected with each child which very few teachers understand. Many times children, at quite a tender age, begin to imitate their parents. The father near-sighted, the children will do the same in their imitation. It is a psychologic effect upon the child's mind. When the child goes to school it studies in this way, through habit acquired at home. I bring this up to show only the mental factor in causing diseases of this tender school age, especially between the ages of 6 and 9, and even up to 15. I do not think sufficient attention is paid to child-study. Many times we find the child will study in school with mouth wide open, listless. There is a slight defect in the posterior nares that can be easily corrected. School directors should be made aware of certain things which affect children, and it should be their object to prevent disturbances that result therefrom. School-teachers should be better trained in child-study, the study of the mental states of children.

I think there is another trouble with school life. There is too much teaching, and not enough of educating. Children write too much, while much of the work could be done without pen, paper or book. Natural phenomena can be studied without book, easily through specimens. Even mathematics, for the first two or three years can be taught without the book. I think they usually commence the subject of mathematics too early. In other words, if the children were compelled to write only one hour a day and the rest of the time were spent in oral teaching, I think most of these deformities would be prevented.

DR. W. E. BRUNER: Dr. Upson and I visited the High School on Tuesday of this week. The afternoon was one when the light was certainly up to, if not better than the average, and yet in several of the schools we found the pupils working under artificial illumination, four small open burners in a large room, an entirely inadequate light. That bad illumination has a great deal to do with the development of myopia, has been so abundantly proved by oculists the world over, that it is practically useless to further discuss the question. Dianoux has reported to the French Ophthalmological Society that he found a large number of students in the schools of Nantes suffering from spasm of accommodation. It is well known that the continuation of spasm of accommodation is often a precursor of myopia. Upon his suggestion radical changes were made in the illumination of the schools. After a time he again made a series of examinations and found a marked decrease in the number of cases of spasm of accommodation.

In regard to the desks, I noticed a great disproportion between the pupils and the desks. The continued use of the eyes at that close distance, made necessary in many instances by the improper desks, is very apt to develop myopia.

In regard to the study made by Dr. Risley, to which Dr. Baker has referred, if it proves anything at all, it does prove that we need to exercise

not less but even much greater care in regard to the pupils in our schools ; that our whole duty has not been done when the hygienic surroundings have been made as perfect as possible, but that every child should have his eyes examined upon entering school and at stated intervals afterwards.

DR. SHERMAN (closing the discussion): I wish to stand here boldly and make the assertion that in the High School we have a condition of things that is a disgrace. We have here rooms in which over one-half of the pupils are subjected, under the most favorable conditions, to light which will ruin their eye-sight. I want to say to you that the first three rooms next to the blind wall do not furnish a sufficient amount of light, under the most favorable conditions, for physiological optical conditions. I wish to defend that statement at any time and anywhere.

I wish to say, furthermore, that in only five or six rooms in all of the thousands of rooms in this city, are the desks arranged with any reference to the pupil. Of course the present authorities are making all efforts to bring the model desk into place, but they are bringing it only here and there. The *tendency* is all right. I have no criticism to make on the present regime.

(Dr. Sherman here placed before the Society a desk and child to illustrate the evils mentioned.)

It is now mandatory in the government of France that in every school-room, not only shall a certain amount of light be admitted to the room, but by photometers a certain amount of light shall be given to every seat in that room. That is the result of the investigation of the Academy of France.

Now, gentlemen, when you visit the public schools don't knock and have the teacher come to the door. Do not introduce yourself. Don't attract attention. Take hold of that door gently and step in, just as if you were shot in, and see them squirm around and wriggle and straighten up.

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### Notice to Librarians and to Physicians Having Used Medical Periodicals

Dr. George M. Gould, 925 Walnut Street, Philadelphia, requests librarians of Medical Societies, Colleges and Associations to send him lists (with precise dates, etc.,) of such periodicals as they need to complete their files.

He also begs physicians (or legatees) to send him accurate lists of such periodicals (or books) as they are willing to donate to libraries. Lists only are desired, not the periodicals themselves, until after correspondence it shall have been determined: (1) Where they are needed. (2) Where they will be properly cared for. (3) Where they will do the most good to Medicine.

It is Dr. Gould's intention to aid established libraries in completing their files by thus forming a kind of *gratis* exchange, and to encourage the formation of new public libraries by utilizing some of the vast number of valuable medical publications at present going to waste or destruction.



## Medical News

**The plague** has reappeared in Hong Kong.

**Dr. Tressel** of Alliance was in town on March 10th.

**Dr. C. F. Putnam** of Minerva, made a short visit to this city March 9th.

**Dr. C. W. Smith** was laid up with the grip a few days in the middle of March.

**Dr. C. O. Arcy** announces his return to his original profession of architecture.

**Dr. C. F. Hoover** has moved his office from 95 Huron Street to 282 Prospect Street.

During his stay in the city, **Dr. N. P. Dandridge** was the guest of **Dr. Dudley P. Allen**.

**Dr. and Mrs. H. J. Herrick** returned March 10th from a southern trip of some duration.

**Dr. L. B. Tuckerman** was elected a member of the Chamber of Commerce on March 17th.

**Osler** reports a case of Addison's disease much benefited by treatment with suprarenal extract.

**Dr. E. Tate** of Barberton, is a member of the State Executive Committee of the Populist party.

**Dr. William E. Bruner** has moved his office from 282 Prospect Street to 516 New England Building.

The New Orleans *Medical and Surgical Journal*, Ltd., has been incorporated under the laws of Louisiana.

**Dr. Charles C. Arms** has moved his office from 104 Euclid Avenue to the New England Building, twelfth floor.

**Dr. Frederick C. Woodburn**, of Indianapolis, has resigned the Secretaryship of the Indiana State Medical Society.

**Dr. O. Yost** has moved his office from the Permanent Block to the thirteenth floor of the New England Building.

The University of Pennsylvania is arranging to increase the requirements for admission to the medical department.

**Dr. E. C. Savidge** of New York, has published a novel, "The American in Paris," which is highly spoken of by the critics.

**Dr. and Mrs. F. E. Bunts**, with their little daughter, sailed from New York for Europe upon the *Normannia*, March 28th.

Ohio has at last a law regulating the practice of medicine. The bill passed the Senate on February 19th.—*Medical Record*.

**The Bertillon system** for the identification of criminals has been formally adopted by the police board of the city of New York.

**The Medical Department** of the University of Buffalo announces the establishment of a four-year's course with the session of 1896-7.

**Dr. Conan Doyle** has written a story for an English quack-medicine firm which is printed in a book extolling the virtues of the remedy.

**Dr. James J. Shanley** of Toronto, O., died of disease of the stomach, February 20th. He graduated from the Miami Medical College in 1874.

**Dr. Nathan A. Harris**, one of the most prominent physicians of Atlanta, Ga., died on March 6th, from the result of an operation for appendicitis.

**A Cuban hospital** in Havana has been looted by Spanish troops and completely destroyed. This to show the world Spain's humane methods of warfare.

**Dr. W. E. Williams** of Jackson County, is a member of the 10th District Republican Congressional Convention, being the Jackson County representative.

**G. T. Holmden** of the Western Reserve Medical School, was recently appointed, by competitive examination, to serve as House Physician to the St. Clair Street Hospital.

**Dr. Lillian G. Towslee** has removed to her new residence at 554 East Prospect street. She will, however, continue to have her office at the old number, 343 Prospect street.

**The New York Legislature** has been asked to legalize the "Keely Cure," by the passage of a law compelling every man twice convicted of drunkenness to take the cure.

**Dr. Charles Mossbacher**, of Toledo, was found dead in the bathroom of the house of a cousin of his, with a bullet-hole in his head, and a revolver lying at the opposite side of the room.

**The dental profession** is in the throes of an attempt to have the legislature pass an improved law governing the practice of dentistry, the present one being, it is said, entirely inoperative.

**The Imperial German Health Bureau** recently investigated the suitability of aluminum for cooking utensils and found that it was absolutely free from any contaminating influence upon food.

**Dr. C. B. Parker** will address the Cleveland Medical Society on the evening of April 10th, upon the subject of "Anesthetics." He will demonstrate upon a subject a new method of rapid anesthesia.

**The Lakeside Hospital** was closed April 1st, pending the completion of the new building. Work on the latter is being pushed rapidly and it is hoped that it will be ready for occupancy in the early fall.

It is announced in *Science* that with the April number the *American Meteorological Journal* will cease publication. The *Journal* has been published at Ann Arbor for twelve years, but its demise is due to lack of support.

The *Medical Record* attained the thirtieth year of its age on Saturday, March 1st, its first number having been issued March 1st, 1866. A very wide circle of the medical profession will wish the *Record* many happy returns of the day.

A sudden death from the administration of diphtheria antitoxin occurred in this city February 19th. The child, who had a mild attack of diphtheria, died one hour after the injection of the antitoxin. The actual cause of death is not known.

Examinations were just held to fill vacancies on the House Staff of the City Hospital. Appointments were given, in the order named, to W. O. Osborn of the Cleveland Medical College, W. G. Morse and C. H. Tanner, of the Western Reserve School.

Dr. W. M. Coplin, Professor of pathology at Vanderbilt University, Nashville, Tennessee, has been elected to the chair of pathology and bacteriology in Jefferson Medical College. Until last year he held a subordinate position in the Jefferson College.

The newspapers state that Dr. Joseph M. Thayer was found dead in bed at a hotel in Los Angeles, Cal., on February 27, with an empty chloroform bottle by his side. Whether death was by intention or accident is not known. The body is to be buried in Cleveland.

Dr. Fred C. Taylor has the sympathy of his many friends because of the death of his father, Mr. DeWitt Clinton Taylor, February 19th, at the age of 72 years. Mr. Taylor was one of the oldest and most prominent residents of the city and had been a leading real estate man.

From the *Bulletin of the American Medical Publishers Association* we learn that the Columbia Chemical Company of Washington, D. C., which was organized to market Dr. William E. Hammond's very remarkable animal extracts, is in the hands of the United States Marshal.

Congress has passed a bill which has been signed by the President incorporating the Post-graduate School of Medicine of the District of Columbia. Real and personal property to the amount of \$200,000 may be held by the school. The *Record* states that the school is to be opened shortly.

Ohio has just acquitted herself in a most commendable way by passing, without amendment and with only one dissenting vote, a law regulating the practice of medicine. The profession of that State are to be congratulated upon this unprecedented success as a result of almost a quarter of a century of patient effort.—*Medical News*.

**Fifteen resident** and 52 non-resident members have been elected to membership in the Cleveland Medical Society since the first of this year. It is remarkable that this society still maintains its phenomenal rate of growth.

**The regular** quarterly meeting of the Northern Ohio District Medical Society will be held at Bellevue Thursday, April 16. The Secretary announces that a good program has been arranged and an unusually interesting meeting is anticipated.

**Dr. Eli Conn** of Akron, a member of the House of Representatives of the present State Legislature, is having some trouble with his constituents over his vote against the Harris local-option bill. They charge that he was pledged to vote for the bill, and demand his resignation. The doctor denies that he was so pledged, and refuses to resign.

**Natural laws** are inexorable, and the results of their operations are often full of seeming sarcasm directed to the puny efforts of man. An instance of the "eternal fitness of things" is the death, recently by pulmonary tuberculosis, of the manager of a much-advertised Cincinnati cure for consumption. *The Record* says of him, "Bluffing to the last."

**Senator Avery's** bill prohibiting the sale of cigarets or tobacco in any form to minors, under severe penalty, has become a law. The wisdom of a law to keep tobacco away from children is unquestionable, and it is to be hoped that it will be effective. To the credit of Ohio, not a vote was recorded against the bill in either branch of the Legislature.

**The Cleveland Medical Society** is indeed flourishing. Of this no further proof is needed than the statement that at each of the meetings of February 28th and March 13th, twenty new members were elected. That the Society should be compelled, by the abundance of scientific material offered, to hold weekly meetings in March, is also significant.

**Dr. C. P. Ambler**, late of Canton, has yielded to the urgent solicitation of Dr. Carl von Ruck, to return to the Winyah Sanitarium, Asheville, N. C., and to share with him the management of that institution. Dr. Ambler and Dr. von Ruck will jointly have full charge of the medical department of the institution. Dr. Ambler will also open an office in Asheville.

**Dr. C. J. Aldrich** and family sail for Europe April 8th. The doctor will spend most of his time at the National Hospital for the Insane and Epileptic, where he will study diseases of the nervous system, under the direction of Dr. William R. Gowers. His many friends in this city will wish him a successful and profitable trip. He expects to be gone at least four months.

**A noticeable** item of improvement in this number of the JOURNAL is the fact that the original articles and editorials were set by machine. Few medical journals outside of New York can boast of the service of type-setting

machines. It has the great advantage of giving each month an entirely new type-front to print from, the resulting clean work being plainly perceptible.

**Dr. Herbert U. Williams** of Buffalo, we learn from the *Record*, presented to the Philadelphia Pathological Society, on February 27th, a specimen from an adult of a double aorta from the origin of the left subclavion to the iliacs, each of which had a separate origin. Opinion in the discussion favored the theory of the condition being the result of a dissecting aneurism.

**The Mount Sinai Free Dispensary** has been opened at 146 Woodland Avenue for the purpose of giving free medical, surgical and dental aid to the deserving poor of the city, from 11 A. M. to 4 P. M., daily. The new institution proposes to meet a long-felt want. The staff is made up as follows: Drs. Loewenthal, Heimlich, Rosenberg, Stegelstein, Stotter and Reich.

**The attendance** at the meeting of the Cleveland Medical Society addressed by Dr. Dandridge was large—over 150. Many out-of-town physicians were present, among others Dr. Gustav Shane of Waynesburgh, Dr. August Rhu of Marion, Dr. Charles Graefe of Sandusky, Dr. W. C. Bunce of Oberlin, Dr. J. P. Boyd of Akron, Dr. A. B. Walker and Dr. W. J. McConkey of Canton.

**Dr. H. H. Little** died of disease of the stomach at his residence on Euclid Avenue, March 9, 1896. He was born in Vermont 1816, graduated from the Ohio Medical College in 1844, and practiced medicine at McConnelssville, O., for twelve years. He then, in 1856, moved to Cleveland, going into the real estate business, in which he was very successful. He never practiced medicine again.

**Dr. N. P. Dandridge** of Cincinnati addressed the Cleveland Medical Society upon Diabetic Gangrene at the quarterly special meeting of March 27. The paper was discussed by Drs. C. B. Parker, D. P. Allen, C. A. Hamann, G. D. Upson, J. H. Lowman, W. T. Howard, Jr., and others. The meeting was a very successful one and will be fully reported in our May number.

**The Ohio State Medical Society** will hold its fifty-first annual convention in Columbus, May 27-29. President, Dr. Dan Millikin, Hamilton; Secretary, Dr. Thomas Hubbard, Toledo; Treasurer, Dr. James A. Duncan, Toledo; Chairman Local Committee of Arrangements, Dr. J. F. Baldwin, Columbus.

Titles of papers should be sent to the Secretary by April 1st.

**The American Laryngological, Rhinological and Otological Society** has recently been incorporated in New York. It is the first society to recognize in its name and organization the correlation of diseases of the ear with diseases of the nose and throat. The Society is born under favorable

auspices, and is composed of men eminent in this line of work. It is a pleasure to note that Cleveland is already represented in its membership in the person of Dr. Howard S. Straight, who is one of the original fellows of the new Society.

**The Aultman Hospital** in Canton has lately added to its facilities a training school for nurses. Lectures are given by the medical staff and the nurses have in addition two recitations each week in anatomy, physiology, materia medica, nursing, massage and bandaging. On the occasion of the graduating of this year's class recently, Dr. Fraunfelter made an address. He gave an account of the origin of training schools by Florence Nightingale, and spoke of the good work that is being done in the Aultman Hospital.

**Dr. Laughlin McFarlane** of Toronto, Canada, died February 29th, of septicemia, of less than a week's duration. While operating upon a frost-bitten foot at the Toronto General Hospital he pricked his finger slightly, but paid no attention to it. In 36 hours, however, stiffness and tenderness of the arm appeared, followed rapidly by lymphangitis, diffuse cellulitis, and general septicemia. Dr. McFarlane was very highly regarded by the profession of Toronto, and his loss is keenly felt. This is the third death of a Toronto medical man from septicemia in a month.

**The Medical Press and Circular** (English) states that Dennis's System of Surgery by American Authors, published by Lea Brothers & Company; Nancrede's Essentials of Anatomy, published by W. B. Saunders & Company; and Leonard's Vest Pocket Anatomist, published by the author in Detroit, have been refused admission to England because of wholesale plagiarism from English writers. Until particulars are given and the defense is heard, it will be best to regard the matter as a mistake, so far as Dennis's System is concerned. It is very difficult to believe that any of the eminent collaborators of Dr. Dennis are guilty of such a heinous offense.

**Dr. Wm. H. Humiston** was in Detroit March 26th, the guest of the Wayne County Medical Society. In the afternoon he gave a clinic to the profession of Detroit at the Woman's Hospital, being assisted in the performance of a laparotomy by Dr. Harold T. Clapp, who had accompanied him. In the evening, at the Hotel Cadillac, the Society, together with the members of the Detroit Medical Society and also those of the Library Association, who had been invited, listened to a paper by Dr. Humiston. The paper was fully discussed. The Detroit Society has learned the value of special meetings addressed by men out of the city and is to be congratulated upon coming to Cleveland for a lecturer.

**The Medical News** states that the committee from the Medical Society of the County of New York and from the New York County Medical Association, which attempted to set aside the new appointments of visiting staffs

to the various city hospitals, under the reorganization by the Commissioners of Charities, by injunction proceedings, has met with signal failure. Judge Andrews decided that these staff positions were not subject to the civil service rules and the Commissioners had the right to appoint whom they choose—all from one school even.

Thus fails the attempt of the medical profession to prevent the monopoly of all the hospital positions by a few members of the faculties of the New York medical schools.

**Dr. Charles H. Springer**, of this city, was on March 19th found guilty of administering drugs to Hattie Malady in 1893, to procure an abortion. He was acquitted of the charge of murder. The defense included evidence that the defendant was addicted to the use of both morphin and cocain, and also an attempt to prove that the abortion had been performed by some other physician, the girl simply dying from its effects subsequently in the defendant's office. Dr. Clyde E. Cotton, of Wooster Medical College, had seen the girl about a month before her death and had bought the body from the defendant for \$20, reporting to the police immediately upon discovering who it was. An unsuccessful attempt was made by the defense to involve Dr. Cotton, whose friends rejoice that the endeavor to besmirch his reputation so signally failed.

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## The Library

We publish this month the second index of foreign periodicals, on file in the Case Library, the property of the Cleveland Medical Library Association. This month's index is in improved form and should prove of value to all our readers.

The library at present is in excellent condition and its prospects for the future were never better. It deserves the hearty support of all the profession of Cleveland and vicinity. Nearly 100 medical journals, both domestic and foreign, are constantly on file and the collection of bound volumes of periodicals is quite representative.

The following new books have recently been added:

"American Text Book of Obstetrics."

"American Text Book of Diseases of Children."

"American Text Book of Nervous Diseases."

Senn's "Principles of Surgery."

"Auto-Intoxication," by Bouchard.

Hayem and Hare's "Physical and Natural Therapeutics."

A very valuable addition has been made, consisting of a complete set, about eighty (80) volumes, of the British Medico-Chirurgical Transactions.

Communications in regard to membership, etc., should be addressed to Dr. Wm. E. Bruner, Secretary, 514 New England Building.

## A Few Opinions

*The Medical Record* says (November 16, 1895), "Avoid subscribing to medical journals which have not good and well known pedigrees on the sides of both publisher and editor."

The *Western Reserve Medical Journal* has merged into the CLEVELAND JOURNAL OF MEDICINE, and under that name comes out as an independent monthly of a fine appearance.—*Milwaukee Medical Journal*.

The first number of the CLEVELAND JOURNAL OF MEDICINE is before us. It is an able exponent of Cleveland medicine and a worthy offspring of the Cleveland Medical Society, whose interests it vows itself to cater to. Success to you, brethren.—*Illinois Medical Journal*.

CLEVELAND JOURNAL OF MEDICINE—This is the name of the successor to the *Western Reserve Medical Journal*, the first copy of which has been duly received. It is offered as the official organ of the Cleveland Medical Society, is edited by Dr. Henry S. Upson and Dr. P. Maxwell Foshay, and no doubt it will prove an acceptable addition to current medical literature.—*The American Therapist*.

We are in receipt of the first number of the CLEVELAND JOURNAL OF MEDICINE, and if we were to base a prophecy upon the general features of Vol. I, No. 1, it could not be other than very flattering. The editorial entitled "Infant Feeding in Cleveland," is a classical production, and is deserving of wide attention. The *Reporter* joins in wishing the promoters success in every sense of the word.—*New York State Medical Reporter*.

A valued correspondent writes as follows: "You are to be congratulated upon the excellent work you are doing. Your JOURNAL has always been conducted upon a high plane. When one sees, as I do, the various hybrid journals which are issued he knows how really few are journals of the tone of the CLEVELAND JOURNAL OF MEDICINE, *Pittsburgh Medical Review* and *Medical News*. Stick to it! We may be able to drive out some of these trashy advertising sheets which call themselves journals."

A NEW MEDICAL JOURNAL.—With the last issue of 1895 the *Western Reserve Medical Journal* suspended publication, to be succeeded in the new year by the CLEVELAND JOURNAL OF MEDICINE, which has been constituted the official organ of the Cleveland Medical Society. The JOURNAL is full of enthusiasm. Commercial activity, a medical library association, ambitious medical schools, which aim to make their city the future medical center of Ohio, a recent liberal gift to one of the colleges, and lectures by distinguished visitors, form a combination which justifies pride.—*Medical Bulletin*.



## Index of Foreign Medical Journals

Received by the Cleveland Medical Library Association from February 15th to March 15th, and now on file in Case Library

DR. C. A. HAMANN, Librarian. DR. W. E. BRUNER, Secretary.

For Index of American Journals see the American Medical Review

## KEY TO MEDICAL JOURNALS

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## Condensed Table of Mortality in Cleveland for February 1896

By courtesy of Dr. J. L. Hess, Health Officer

## I—ZYMOTIC DISEASES

Measles .....	0
Scarlet Fever .....	1
Diphtheria .....	9
Croup .....	10
Whooping cough .....	1
Typhoid-fever .....	10
Cholera, cholera morbus and cholera infantum .....	5
Acute diarrhea .....	0
Chronic diarrhea .....	1
Dysentery .....	1
Cerebrospinal meningitis .....	1
Erysipelas .....	0
Malarial fever .....	2
Pyemia and septicemia .....	4
Alcoholism .....	0
Inanition .....	10

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## II—CONSTITUTIONAL DISEASES

Cancer .....	12
Rheumatism and gout .....	0
Marasmus, scrofula and <i>tuberculosis mesenterica</i> .....	9
Hydrocephalus and tubercular meningitis .....	0
<i>Phthisis pulmonalis</i> .....	30
Anemia .....	0

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## III—LOCAL DISEASES

Pneumonia and congestion of the lungs .....	25
Bronchitis, acute .....	5
Bronchitis, chronic .....	2
Tonsillitis .....	1
Pleurisy .....	0

Asthma .....	2
Congestion of brain and meninges .....	14
Apoplexy .....	5
Paralysis .....	12
Epilepsy .....	0
Tetanus .....	0
Convulsions .....	28
Other diseases of brain and cord .....	1
Diseases of heart .....	18
Aneurism .....	0
Abscess .....	0
Dropsy .....	11
Diabetes .....	1
Bright's disease .....	3
Peritonitis, gastritis and perforation .....	17
Hernia and obstruction of intestines .....	1
Diseases of liver .....	5
Genitourinary diseases .....	2
Hip disease .....	1

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## IV—DEVELOPMENTAL DISEASES

Puerperal diseases not septic .....	3
Infantile debility .....	29
Dentition .....	1
Senectus .....	32

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## V—DEATH BY VIOLENCE

Accidental .....	10
Homicide .....	1
Suicide .....	5

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Total deaths for January, 341. Total deaths for January, 1895, 413.

Annual death-rate per 1000 during the month (estimated population 330,279) 13.002+

Reprints of articles will be furnished authors at a reasonable price.

All remittances to the journal should be made payable to THE CLEVELAND JOURNAL OF MEDICINE.

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## Amputation in Diabetic Gangrene

BY DR. N. P. DANDRIDGE, CINCINNATI

I MAY, perhaps, properly introduce what I have to say on the subject of amputation in diabetic gangrene by the recital of the facts of a case which has recently come under my care.

A. R., age 64, German, cabinet-maker by trade, entered the surgical service of the Cincinnati Hospital January 22d, with the following history: In 1885 his weight was 250 pounds; at present it is not more than 130. He now passes more urine than usual, but has not been affected at any time by excessive hunger or thirst.

January 1st, 1896, he began feeling a stinging in the left foot, especially in the toes, and in a few days later the toes became cold, numb and turned black. A week later he consulted a physician who removed the great toe. The man was not able to give any intelligent account of his condition before entering the hospital, so that it was impossible to determine the exact condition of the other toes at this time. On admission it was found that the great toe had been removed at the metacarpo-phalangeal joint, leaving an ill-conditioned ulcerated stump. The remaining four toes were black, and for about three inches upon the sole and dorsum there were patches of greenish discoloration of the skin. The whole foot as far as the ankle was reddened and swollen. The part was insensible to the touch of a pin, at the same time the patient complained of a burning sensation. The superficial arteries all showed a marked arteriosclerosis. On examination the specific gravity of the urine was found to be 1.038. There was an abundance

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*An address delivered before the quarterly special meeting of the Cleveland Medical Society, March 27, 1896*

of sugar present, but no albumin. The quantity passed was oz. 65 in 24 hours. The man was at once put on morphin grs.  $\frac{1}{4}$  three times a day, and in a few days was confined to strictly diabetic diet.

His general condition at once improved, the swelling of the foot subsided, and the pain disappeared, but the toes and affected portion of the sole and dorsum assumed the typical appearance of moist gangrene, with a commencing line of demarcation, and the characteristic offensive odor. The entire foot was kept constantly in phenol poultices; the amount of urine diminished and the specific gravity reached 1.032. The temperature ranged a little above normal.

February 2d, eleven days after admission, it was decided to amputate. The morphin was increased to gr.  $\frac{1}{4}$  three times daily, and the next day an amputation was made through the knee-joint by lateral flaps. At the site of section the popliteal artery was found thickened with yellow atheromatous patches, but not calcareous. Rubber tube was used for drainage. The arteries of the leg and foot were markedly calcareous throughout. The night following he slept well, and in the morning was free from pain, but slightly delirious. On the fourth day the dressings were changed, the drainage-tube removed, and the wound was found free from discharge and apparently united throughout. The delirium continued, though somewhat less; the morphin was diminished, and bicarbonate of soda freely given. The urine had diminished to 49 ounces. Saccharin was now given as he complained of the absence of sugar. The delirium continued and the feces and urine were both passed involuntarily. Free stimulation with strychnin was tried, and hot-air baths given, without, however, controlling the delirium. During the last day or two of life albumin in quantities was found. He died February 20th, 18 days after the operation, with symptoms which pointed to uremia.

The post-mortem was made by Dr. Holt, pathologist to the hospital, 20 hours after death: rigidity and staining well marked. White man, aged 70 years, well developed but poorly nourished. Recent amputation of left leg below knee; flaps have not yet healed. Lungs—few old adhesions, somewhat congested but otherwise normal. Pericardium normal. Heart—no marked valvular changes, though slight and diffuse atheromatous changes at base of the aorta. Thoracic and abdominal aorta marked state of calcareous degeneration. Liver—general congestion, no marked cirrhosis. Spleen—enlarged and soft as usually found in acute infectious diseases. Splenic artery very much dilated and decidedly calcareous. Kidneys—slightly cirrhotic, although portion between cortical and medullary substance about normal. Capsule not adherent and no cyst in substance. Stomach and intestines normal. Pancreas—somewhat diminished in size and hardened. Urinary apparatus and bladder normal. Brain—some edema, marked scler-

otic changes in vessels of the base, but no gross lesions apparent in floor of fourth ventricle or floor of medulla. A cyst with soft wall about size of pea found in middle portion of lower left lenticular nucleus.

Tuesday, in passing through the operating-room of the Cincinnati Hospital, I found Dr. Walker, my colleague, just finishing an amputation of the lower third of the thigh for gangrene of the toes and foot. The history of the case was as follows: Age 60; within some years he had lost 80 pounds weight. He has been passing for a long time large quantities of water, and has often a ravenous appetite. Three months ago he had his feet frost-bitten and six weeks ago they began to turn black. The urine was found to be 1.040, and to contain an abundance of sugar. I had the arteries and nerves of the leg dissected out, and here present them for your inspection. The arteries are calcareous throughout. At the amputation the Esmarch tourniquet had little effect in controlling hemorrhage. The nerves are enlarged and indurated. I unfortunately have not had time to have a microscopic section made. The day after operation the man was in excellent condition.

A consideration of the foregoing case calls up a number of questions of interest, especially to the operative surgeon. We have a case of gangrene of a toe, rapidly followed by infection, and spreading gangrene after the removal of the affected part, and later the development of a fatal uremia after a second amputation at a distance, while the operative wound proceeded unaffected to repair. It brings up the far-reaching and interesting questions involved in the reciprocal relations which exist between accidental or operative trauma, and constitutional conditions or disease. These problems the operative surgeon is often called on to solve. It so happens that I now have under my care in the Cincinnati Hospital two cases which illustrate these facts very clearly. The first one entered the medical service several months ago with marked jaundice of uncertain origin. This, under treatment, disappeared, and he was transferred to the surgical service on account of a large hernia of long standing. After watching him for several weeks his condition was so much improved that it was decided to operate. A Bassini operation was made; in a few days a marked jaundice occurred with general depression and fever. The wound has, however, healed by first intention throughout in the most perfect manner, and the jaundice has now about disappeared. Here the operative trauma reacted upon the general condition while local repair was entirely unaffected.

The second case was that of a young man who came into the hospital on account of an extensive ulceration involving five or six inches of the anterior surface of the tibia. There was a sharp anterior curvature, with an unusually prominent and projecting spine. He had been burned when a child and the skin had never developed well over this part since then. The prominent spine was chiseled off by Dr. Oliver, who had charge of the

service in my absence, and the skin grafted. The grafts failed to take. This boy, several years ago, had for six months severe chills and fever in East Tennessee. Several months after the first operation I attempted to close in the exposed bone by a plastic operation. The operation was at once followed by a severe development of malarial fever with recurring chills and intermittent fever, and fully one-half of the flaps have sloughed. The operation here again reacted on the general condition, calling forth a recrudescence of a latent trouble, and the general condition probably reacted disastrously upon the vitality of the flaps; it should be remarked that this patient had been given quinin freely during the first week of his stay in the hospital with the effect of removing all his malarial symptoms.

The danger from increased susceptibility to infection can often be successfully met by more than usual care in operating, as was shown in my first case, and the influence of the general condition is not made manifest. But there are regions where perfect asepsis is impossible, as for example, about the perineum or genitourinary organs of the male, and here we often see repair of operative wounds most seriously affected, especially in cases of diabetes or chronic Bright's disease.

The findings of the post-mortem in the case I have reported are very characteristic of a long standing diabetes, marked arteriosclerosis throughout the body, with a decided induration of the pancreas. Pancreatic lesions are now recognized as having a decided influence on the production of diabetes. The frequency with which diabetic patients suffer from gangrene depends according to the more recent writers upon three different factors.

1st. Upon the diminished resistance of the tissue to the germs of infection.

2d. To the condition so often present of arteriosclerosis, a fact which makes diabetic gangrene resemble simple senile gangrene.

3d. Neuritis, which accounts in part if not fully for the severe pains felt by diabetics.

Treves says that "ulceration and also gangrene are very apt to occur in diabetics, more especially in the lower extremities after slight injury, partly no doubt because the tissues of a diabetic individual are particularly prone to become infected with micro-organisms, partly also because the arteries are very apt to become affected with endarteritis, and possibly in part also owing to interference with the proper innervation of the body." The two first causes are undoubtedly the more frequently active and the more important; the latter is not, however, to be ignored.

Godlee (Trans. Med.-Chir. Soc., Vol. 76), after quoting Weniwarter to show that thickening of the sheath of the posterior tibial nerve is observed with arthritis and phlebitis, says that in "those cases in which the gangrene is painful and spreads rapidly, the cause is most likely to be chiefly arterial

degeneration; while in those that are almost painless and very chronic it probably depends upon changes in the nerves." He further argues that the first must be treated by amputation at a distance, "while the latter may be left for the chance of separation by natural means, or by removing the necrosed part within a short distance of the completely or imperfectly formed line of demarcation." The liability of diabetic patients to inflammatory affections is shown by the frequency with which they are attacked by boils and carbuncles; conditions which show a decidedly diminished resistance of the tissues to the invasion of pyogenic germs.

In the case I have cited it seems likely that direct infection of the operative wound, and closure of the arteries both played a role in the development and progress of the case. I was not able to learn the exact extent of the gangrene when the big toe was amputated, but it does not seem probable that this toe alone would be removed when the others were markedly affected. It seems therefore not unlikely that they became involved subsequently to the amputation; the sloughing condition of the stump certainly showed that infection had taken place. The advanced condition of atheroma of the anterior and posterior tibial vessels was, however, fully sufficient to explain the gangrene by the diminution of the blood-supply.

Diabetic gangrene resembles in many essentials senile gangrene; indeed it would seem in many cases to be practically identical with it, namely, dependent upon an arteriosclerosis. It is usually of the moist variety, is rapid in its course, and generally occurs in old people, though it may appear in younger life. With the exception of those cases in which only a limited and superficial area is involved, as when a single toe is affected, or when we meet with a painless perforating ulcer, in both of which cases cure may result, diabetic gangrene tends to a rapid and certain death.

The question of amputation in these cases was, until recently, almost without a dissenting voice answered in the negative. The dangers apprehended were first from death of the flaps, due either to infection, or from the fact that amputation was not made sufficiently far from the gangrene to be beyond the atheromatous condition of the arteries. Sloughing of the flaps is certainly even now the rule after amputation through the leg for gangrene of the foot, while if amputation is made through the thigh, perfect healing is often secured. Secondary hemorrhage for the same reason was formerly of not infrequent occurrence. These dangers can largely be removed by strict antisepsis and high amputation.

There is, however, another danger quite independent of the site of operation, and that is the rapid development of diabetic coma, or uremia. A fatal termination may thus take place while the local wound is in full progress of repair. As regards the frequent termination of diabetes in coma, Osler says: "Our knowledge of the disease is not yet sufficiently advanced



to give a rational explanation. The character of the attack, and the similarity in many instances to uremia would indicate that it depended upon some toxic agent in the blood."

The occurrence of coma after operative interference in diabetic subjects certainly resembles most strongly the frequent fatal termination after operation in advanced disease of the kidneys. This so often follows cystotomy for cystitis in long-standing prostatic hypertrophy, or in stone-operations, whether cutting or crushing, in cases of Bright's disease, or surgical kidney. The frequency with which diabetes is associated with arteriosclerosis and disease of the kidneys, as shown by the occurrence of albumin in long-standing cases, renders it not unlikely that the immediate cause is often, if not always, the same in both classes of cases, namely, the diminished elimination of urea, and that the fatal cases are really uremic.

This fact has, I consider, an important practical bearing, and that is that the amount of urea in the urine may give us some standard by which to determine the probable danger of operation in diabetics. This danger will probably always be responsible for the greater proportion of the mortality, and is directly due to the diabetic disease, and the consequent changes in the tissues, most important of which is probably the wide-spread arteriosclerosis and the consequent want of proper nutrition in the various organs. Whether the danger of diabetic coma after operation can be diminished by preliminary treatment is one of very great importance, and here, unfortunately, there is but little recorded experience.

The following quotation from Treves' "Manual of Operative Surgery," 1892, shows how recently the views on the propriety of operation in diabetics have changed. "Diabetic gangrene of a limb," he says, (page 12) "is scarcely within the scope of surgical measures. An amputation in such a condition is almost invariably fatal."

Treves' System of Surgery, Vol. 1, 1895, page 146, Cheyne says: "From recent work it seems quite evident that the best treatment in the vast majority of cases (diabetic gangrene) is as early an amputation as is possible. By strict antisepsis the inflammation in the stump is avoided, septic troubles are prevented and gangrene does not occur if the amputation is performed sufficiently high up, and as regards diabetic coma the patient is not more liable to its occurrence after amputation than in the course of diabetic gangrene. First in importance undoubtedly is not to delay the operation until symptoms of septicemia have developed, but to amputate promptly. Still I cannot but believe that some few days of strict antidiabetic diet, with the free administration of opium, will be desirable if the local and general symptoms are not too pressing. The preparation of opium does not probably make any material difference. Morphin is the one I prefer, as the most manageable and least liable to disturb digestion. The rapid improvement seen in diabetic

patients when a proper diet is enforced is often surprising, and a few days of such preparatory treatment can, I believe, generally be given with advantage, and should be continued after the operation. In those cases in which there is marked diminution in the elimination of urea, it might be well to stimulate the action of the skin by hot packs, so as to secure profuse sweating and to diminish the probability of uremic symptoms. Such a course is often effective in averting threatening symptoms of uremia in Bright's disease, or of removing them if present. The operation must not, however, be delayed, and the presence of uremic or septic symptoms is an indication for its performance at once. The care of the gangrenous part preceding the operation is of importance. The whole adjacent region should be most carefully disinfected, and dry absorbent dressings freely used and frequently changed. In this way putrefactive and septic changes can best be avoided. High amputation through knee or thigh has now received the sanction of such recent writers as Warren, Koester, Cheyne and Spencer.

In selecting the method of operating, flaps as short as possible should be taken, so as to diminish the chances of death from meager blood-supply; thus, at the knee-joint short lateral flaps, after the method of Stephen Smith, and not the long anterior one.

As all wounds in these cases are peculiarly liable to infection, more than usual care must be exercised to secure thorough disinfection, and when these precautions are taken, a satisfactory healing of the wound may be secured, and is often followed by a marked diminution of sugar, and an improvement in the general symptoms due to the diabetes. In support of the above facts Heidenhain says that in thirteen cases of amputation below the knee, disarticulation of the toes, Chopart and Lisfranc's amputation of the leg, two only recovered; two died of gangrene, and later in nine cases amputation was made at or above the knee; in 27 primary and secondary amputations above the knee, 19 recovered, and eight died of diabetic coma, and in none of these cases did the condition of the wound appear to be the cause of death. W. G. Spencer (Vol. 75, *Medico-Chirurg. Trans.*) bears witness to the same fact. He has, he asserts, only been able to find three cases of recovery where amputation had been made through the leg for diabetic gangrene of the foot. Gangrene of a single toe may recover, and he reports a case of recurrence three times in a single patient within five years. In no case, however, has he seen a case of recovery in gangrene of the foot.

The conclusions I have reached from the foregoing consideration are these. In diabetic gangrene of a single toe recovery may take place and should be waited for. The patient should be put upon a rigid diabetic diet with the free use of opium, and the affected part and adjacent region rigidly disinfected. Whenever gangrene appears on the dorsum or sole of the foot, amputation should at once be performed through the knee-joint, or lower

third of the thigh, and this gives a fair chance of complete recovery, with prompt healing of the stump and may be followed by a diminution of the sugar. Amputation through the leg should never be performed for gangrene of the foot. The same conclusions apply also to senile gangrene.

148 Broadway

## A Case of Glaucoma

BY DR. B. L. MILLIKIN, CLEVELAND

*Professor of Ophthalmology in the Medical Department of  
Western Reserve University*

ON March 17 last Mr. R., 65 years of age, a large, strong, rugged-looking, well-preserved German, presented himself at my clinic, with the following history: About a year ago the vision of the right eye began to fail, and gradually diminished in acuity, until three months previously, when he became totally blind in it. There had been no history of pain up to that time, only the diminished vision and the appearances of halos about flames. Three months ago he had a sudden sharp attack of pain, ushered in with considerable redness of the eye-ball, the pain extending through the entire right side of his head. This continued exceedingly severe until the time of his visit to the clinic.

For some weeks he had noticed the sight of the left eye becoming somewhat dim, but accompanied with no pain. He had visited a number of physicians, who had given various treatment for the condition present. Examination showed complete blindness in the right eye, with no light-perception present; of the left eye vision  $\frac{5}{14}$ . The right eye was slightly reddened, the pupil widely dilated, fixed, not responding at all to light, the lens cataractous, the tension + 2. The left eye tension + 1, the pupil responded fairly well to light and was not dilated. Examination of this eye with the ophthalmoscope showed the fundus of the eye entirely normal, with the exception of cupping of the disc, to the extent of 2D. There seemed to be no contraction of the objective field, but the color-fields were only roughly tested. The suffering of the man was so evidently intense that removal of the right eye was the only proceeding advisable at the time. He was sent to the hospital, and on the following day the right eye was enucleated, and a broad iridectomy upward of the left eye was performed. Careful antiseptic precautions were taken in both operations, and a compress and bandage applied to each eye. From a condition of intense pain, which rendered the man unable to secure sleep, a sense of complete relief was afforded immediately. In the lecture the day previously before my class,

*Read before the Cuyahoga County Medical Society, April 2d, 1896*

this case had been exhibited and the diagnosis of cataract made by nearly every member of the class. I have so frequently seen the exact counterpart of this history, that I have thought it advisable to call your attention to the differential diagnosis of glaucoma and cataract, which seem to be so frequently mistaken for one another. Not long since, a case was referred to me from a very good practitioner in the vicinity of Cleveland, with the report that the case was ready for operation for cataract, only that he had had some little inflammation with pain for a short time previously. Upon making an examination of the case I found it one of absolute glaucoma, with little or no hope of improvement in the condition of his eye. Of course the prognosis in the two classes of cases is so absolutely different that a mistake in the diagnosis in the one case proves fatal.

The characteristic symptoms of glaucoma are so definite that no one who is at all familiar with these cases should be guilty of a mistake of this kind. The failure of vision may be gradual or sudden, depending upon the rapidity of the development of the attack of glaucoma. A case showing gradual diminution of vision, accompanied with halos or rings of light about a flame, either with or without pain, should always put one sharply on his guard in diagnosing the condition. If in addition there be present dilatation of the pupil with poor response to light, increased tension of the eye-ball, even without an ophthalmoscopic examination we may be pretty sure of the presence of glaucoma. As we all know, in uncomplicated cases of cataract there is never pain as a characteristic symptom. Simply the gradual loss of vision with what may seem to be an opacity of the lens, should always lead us to an examination of the lens with the ophthalmoscope, in order to determine whether or not there are opacities present in that body. This will at once determine definitely the development or non-development of cataract. We cannot trust our unaided vision in ordinary light to determine this point. We must remember that in cases of cataract attacks of glaucoma may supervene, and not infrequently do, and in such cases the treatment must be prompt and radical in order to preserve the chance of saving the patient's vision. Whether we are certain or not of opacities of the lens, where there develop the symptoms of severe pain in the eye-ball, extending through the side of the head, neuralgic in character, with marked redness of the eye-ball, indicating deep congestion, we may be sure we are in the presence of serious trouble, and no palliative measures are to be thought of.

The treatment of such a case must be very prompt or we shall certainly lose our patient's eye. Unless we are certain of an attack of iritis, which may occur in elderly people, who are mostly the subjects of attacks of glaucoma and of cataract, the prompt use of eserine to contract the pupil will be pretty sure to give temporary relief. I have found that many of these cases are treated with morphia, hot applications, occasionally leeching,

rest, etc., all to no purpose. In all cases of acute attacks of glaucoma, relief is quite certain to be prompt and permanent by a broad iridectomy, which relieves at once the tension of the eye-ball and as a rule prevents the recurrence of attacks. If the case is one of cataract the element of time is a very indifferent matter; if it is a glaucoma, no time should ever be lost in at once proceeding to radical measures. When the perception of light in eyes subject to glaucomatous attacks has been lost even for a few days, the outlook in the case is almost hopeless so far as restoration of vision is concerned. In the case we have detailed there was no possibility of in any way relieving the patient's condition, in the right eye, and this was sacrificed simply to protect the patient against the serious disturbance due to pain and consequent loss of sleep. The operation in the other eye was performed with the expectation of saving what vision was present, and possibly preventing the increased loss of vision. The results have been thus far perfectly satisfactory, and the vision is now, only two weeks after the operation, better than before. I thus very briefly call your attention to this serious trouble in order, if possible, to enforce the necessity of a definite knowledge of these conditions, their histories and their results, so that a fatal mistake in diagnosis may not be made.

278 Prospect Street

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## On Lake Erie as a Water-Supply for the Towns on its Border (Abstract)

BY GEORGE W. RAFTER, C. E., ROCHESTER, N. Y.

IN sanitary matters European cities are far ahead of ours. There are as yet almost no sanitarily unobjectionable water-supplies in the United States. Liverpool draws its water from two impounded mountain streams having a combined catchment area of 28,000 acres. These sources are carefully protected from contamination, nevertheless all water is filtered before delivery to the city. The death-rate from typhoid is remarkably low, especially as Liverpool is the most densely populated city in Great Britain. Zurich obtains its water-supply from the effluent stream of the lake of the same name. Careful studies have been made there of the relation of contaminated water to typhoid. The water and mud of the lake-bottom are proved to be laden with bacteria. Despite the unusual purity of lake-water experience has taught the city to filter all water before delivery. Freezing over of the lake was proved to be very detrimental to the purity of the water, by preventing surface oxidation and permitting the anaerobic bacteria

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This paper was read by the author before the Microscopical Club of Buffalo, January 13. By courtesy of the author and also of the president of the Club, Dr. Frank J. Thornbury, we are very fortunately enabled to furnish our readers an abstract of this excellent paper by an eminent engineering authority upon a topic whose importance to the health of Cleveland cannot be overrated. The full paper appears in this month's *Buffalo Medical Journal*.

(which include the typhoid-bacillus) full sway. The breaking up of the ice was found to be marked by an enormous increase in the number of bacteria.

Lake Erie is 240 miles long by 40 miles (mean) wide and has an area of 9,522 square miles and a catchment area of 21,370 square miles. The depth hardly averages 60 feet.

I will not take time to give statistics of population in the Lake Erie catchment area and the consequent amount of sewage which daily finds its way into its waters. It is enough to say that the populous cities of Detroit, Toledo and Cleveland, as well as a number of smaller towns, all send their sewage, absolutely without treatment, to mingle with its waters, from which Cleveland, Erie, Dunkirk, Buffalo and other towns take their water-supplies, that is to say the citizens of these several cities complacently drink raw water containing raw sewage.

The bottom silt of Lake Erie is stirred up by every gale, bringing up all deposited filth. In April and May I examined Lake Erie carefully as a source of water-supply, with reference to water-works extensions for the town of Lorain. The sewage of both Elyria and Lorain empties into the Black River and during the dry season much dangerous filth gathers in the bottom of the river, to be suddenly swept out to the water-intake of Lorain by the first heavy rain. Black River has a flood flow of 15,000 or more cubic feet per second, which amounts to 1,116,000,000 cubic feet in 24 hours, that is ten feet depth of water on a four square-mile area, or one foot on 40 square miles. Hence, we may say it follows with the certainty of a proposition in mathematics, that a water-supply taken in the vicinity of the mouth of a stream like the Black River is liable at times to serious contamination.

The bacteriologist of the Buffalo Health Department has made repeated and careful examination of Lake Erie water. Simple sedimentation of the water in reservoirs reduces the bacteria from 30,000 or 40,000 per c. c. to 400 to 700 per c. c. This shows the necessity for frequent thorough cleaning of the bottom of the reservoirs.

The typhoid-bacillus is so difficult to find in free water that its apparent absence does not render certain the safety of any water.

Returning to the study at Lorain it was ascertained that the sewage system of the town was completed in 1892, and a considerable number of water-closet connections were made in October and November of that year. Previous to 1892 the deaths from typhoid-fever were only such a number as may be expected in the stated population when no special contamination of the water-supply exists. The few deaths actually occurring were in the fall of the year, the normal season of typhoid-fever. This fact leads to the conclusion that for the small amount of sewage then contributed to the Black River by the city of Elyria, the self-purifying agencies of the river and lake are sufficient, and even with the extremely unfavorable location of the intake

no serious contamination took place; but the contribution of even a small amount of raw sewage near the water-works intake was sufficient to destroy at times the small margin of safety which had previously existed. The result is saliently presented by the statistics of Table No. 4, from which it is learned that there was in 1893 and 1895 a serious rise in the typhoid mortality in the winter and spring months, when this disease is not usually prevalent, unless the afflicted population drink sewage-polluted water containing its germs.

A further interesting fact of these Lorain typhoid epidemics is that during the winters of 1893 and 1895 Lake Erie was frozen over and remained closed for several weeks, during which time we must conclude that because of the removal of the antagonistic agency of the aerobian forms of minute life, the bacillus of typhoid-fever attained far greater development in Lake Erie water than is possible when the lake is open. The closing of the lake, then, by ice must be considered the same here as at Zurich, a source of danger to any town using the raw water for domestic purposes. Taking into account that thus far the Lake Erie water-supplies are all unfiltered and that in some years the lake is closed as much as three months, we are forced to the conclusion that this one consideration is a serious menace to every water-supply on the lake.

As to the remedy to be applied to Lake Erie water, sand-filtration is the only proper one thus far worked out. By this I mean filtration through broad beds of sand and not by mechanical filters. This method of filtration has been in use abroad for so long a time as to accumulate a body of experience which adapts it to every conceivable situation. Indeed it has been used at the cities of Poughkeepsie and Hudson in this State successfully for 25 years.

It may be pointed out, however, that the fine clay silt to which we have referred as present after every storm, complicates the problem of filtration of Lake Erie water to the extent that apparently settling basins of large area are a necessary adjunct of any filtration plant here.

The sands of the lake beach while clean are still not quite of the proper quality for efficient filtration as at present understood. Their use would greatly decrease the cost of a filter-plant in comparison with what it would be if necessary to transport the sand from the ocean beach.

The management of the fine clay silt and the adaptation of the local sands are, then, the two problems for the Lake Erie towns to consider, and I cannot but think that more progress will be made toward a final solution by attacking the problem seriously and with due understanding of what has been done elsewhere, than by assuming, as most of the Lake Erie cities have done, that in some way (thus far unexplained), Lake Erie has been excepted from the universal laws of water pollution which prevail in all other

parts of the earth. At any rate, the latter state of mind is not conducive to useful scientific results.

The time at my disposal will not permit of further discussion of these interesting, as well as vastly important municipio-economic questions. From the presentation we may draw the following conclusions:

(1) Taking into account all the conditions, the diversity of practice between the Lake Erie cities and Liverpool and Zurich, is so great as to be only explainable on the basis that somewhere the municipal authorities are entirely wrong. If in Liverpool and Zurich then the people's money has been spent extravagantly and unnecessarily. If, on the other hand, the error is on this side of the water, then the municipal authorities here have assumed very serious responsibility,

(2) Personally, I have no doubt that the European cities are right and ours wrong; the error here is to be ascribed largely to lack of definite information among water-works managers as to just what all the recent biologic information really means.

(3) The remedy is sand-filtration of every Lake Erie water-supply. The use of filtration methods abroad has placed this whole matter on a basis of definite experience, which it is folly on our part to longer ignore.

(4) The cost of filtration if properly designed and the use of water properly regulated will not exceed about 40 cents to 50 cents per capita per annum, a sum which in view of the benefits to be derived our cities can well afford to pay.

(5) The root of the whole matter will be found chiefly in improved methods of administration in the American municipalities. It may be set down as self-evident that a politically governed city will be inevitably far behind in all the arts which go to make life really safe as well as enjoyable.

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## A Case of Puerperal Septicemia

BY GEO. A. BUDD, M. D., CINCINNATI

ON the night of February 13th I was called to see Mrs. C., aged 21, primipara. Her temperature at that time was 104 degrees. She gave the following history: She had been confined one week before of a healthy female child. The labor was rather long but nothing eventful took place. She was attended by a homeopathic physician. Three days after confinement she had a chill, followed by fever. On the fourth day her physician made a diagnosis of child-bed fever and ordered vaginal douches of carbolic acid three grains to hot water two pints three times a day. No improvement followed. On the fifth day he curetted the uterus with no improvement. On the sixth day he curetted again. The patient's tem-



perature was 104 degrees. On the seventh day the physician was going to curet again but the patient objected to being "butchered." The physician insisted and was discharged. I reluctantly took up the case.

Upon examination I found the vagina filled with pus, and the cervix soft and flabby. The uterus was six inches in depth. Diphtheritic membrane was beginning to develop in the cervix. I introduced the recurrent uterine douche-tube and cleansed the uterus of all pus, with a solution of mercuric bichlorid one to 3000. At eight the next morning I found the vagina again filled with pus. The temperature was 103 degrees, the pulse 130. The patient's bowels had not moved for three days. I prescribed calomel one grain every two hours with an intrauterine douche of bichlorid one to 3000. At 1 P. M. the temperature was 103 degrees, the pulse 124, and the vagina again filled with pus. The same douche was given as before. At 7 P. M. the pus was slightly diminished in quantity, the temperature 104 degrees, the pulse 146. The bowels had moved during the afternoon after the intrauterine douche was given. At 12:30 A. M. the temperature was 104.2 degrees, the pulse 150, and the vagina filled with pus. There had been a chill early in the evening and the bowels had moved again. Another intrauterine douche of bichlorid was given.

February 15th the patient's condition was unchanged, the temperature was 103 to 104 degrees, and the pulse from 130 to 140 during the day. The douches were continued every six hours. There was diarrhea. February 16th, her condition was unchanged. Her temperature at 8 A. M. was 103.5 degrees, the pulse 135. I curetted the uterus thoroughly and applied 95 per cent carbolic acid to the uterine cavity. At 6 P. M. the temperature was 101 degrees and the pulse 120. She at this time had the diarrhea of profound sepsis. At 12:30 A. M. the temperature was 101.2 degrees and the pulse 120. The douches were continued. The pus was greatly diminished in quantity.

February 17th, at 8 A. M., the temperature was 102 degrees, the pulse 130, and there was a very small amount of pus. The diarrhea continued. Intrauterine douches were still given. At 1 P. M. the temperature was 102, the pulse 130. At 7 P. M. 95 percent carbolic acid was again applied; the temperature was 103 degrees, the pulse 140. The patient had a chill at this time. At 11:45 P. M. she was in collapse and covered with a cold clammy perspiration, the temperature was 99 degrees and the pulse 160. External heat was applied and whisky and strychnin were given internally. At 3 A. M. her condition was slightly improved. At 8 A. M. her temperature was 101 degrees and pulse 140. There was no pus. For three days after this her temperature remained at 101 degrees and the pulse varied from 120 to 130. The temperature then began to return to normal and in three days more it was 98.4 degrees with a pulse of 115 to 120. The temperature remained at this

point for four days when it went up to 100.5 degrees and the pulse rose to 130. At this time endocarditis developed. In ten days the temperature returned to normal and the pulse to 100. In five days more the pulse had reached 76 and the patient was gaining in strength. There was at no time throughout the course of the disease any abdominal tenderness nor was there much tympanites. Internal medication consisted of quinin muriate five grains every three hours, sulphate of strychnin 1-40 grain every four hours and whisky 24 ounces every 24 hours. The patient is now up and around the house and is well so far as the puerperal septicemia is concerned.

Allow me to ask the question whether this profound sepsis would have taken place had 95 percent carbolic acid been applied to the lining membrane of the uterus after the first curetting instead of leaving the uterine cavity a play-ground for bacteria. Would not this woman have fared better from the beginning with intrauterine douches than from curetting as it was used? Would not this woman have died had the curet and carbolic acid not been used as a last resort?

3519 Warsaw Avenue

### Cases of Smallpox Treated by Local Means

BY DR. GEO. O. BUTLER, CLEVELAND

**D**URING the winter of 1863 variola made its appearance in the city of Frankfort, Ky., among those convicts in the penitentiary who were permitted to work about the city. Within two weeks thereafter a few of the citizens had incurred the disease. The resident physicians, (there being only three, others having joined either the Union or Confederate Army) refused to treat the cases. At that time I was in charge of the U. S. General Hospital. In our possession as a prisoner of war was a Confederate Surgeon, whom I requested to take charge of all the cases of smallpox. He asked if I had ever treated the disease or seen it treated by local means. I replied that I had not. He then requested that I accompany him and observe the method of treatment pursued by the surgeons of the Confederate Army. Upon our arrival at the penitentiary hospital, we recognized two cases of varioloid and one case of variola. He remarked that it was a trivial disease, very prevalent in their army, and that they transported by ambulance all of the cases of smallpox unaccompanied by severe complications, along upon the march and seldom ever had a fatal case.

His mode of treatment was, so soon as a case was diagnosed variola or varioloid, to apply a cantharidal plaster about 10 or 12 inches square upon the anterior aspect of the thorax. As soon as vesication ensued, he would apply a flaxseed poultice, remove the cuticle, reapply the poultice for a day or two, then dress the blistered surface with savin cerate. The discharge from the raw surface was profuse. In addition to this local treatment cathartics, diuretics and diaphoretics were used as required.

I observed this procedure in at least 15 or 20 cases. The *papillae* or red pimples, as large and hard as a bird-shot, would disappear as soon as the blistered surface discharged freely. There were no vesicles or pustules observed whenever the cantharidal plaster was applied before or during the papular stage.

Two of the cases were treated without the local application, and they developed into typical cases of distinct (not confluent) smallpox.

In some few cases vesicles were visible, and would dry up and disappear as would a varicella, the vesicle leaving no scar or pit.

The duration of the disease was materially shortened, none being confined to the couch longer than one week.

During the following winter (1864), the disease appeared in this city in an epidemic form. I then had returned and resumed practice and was fortunate enough to treat some twenty cases at their homes under unfavorable circumstances. The pest-house was full to overflowing. Some of my cases were varioloid and others typical smallpox. I adopted the foregoing treatment, recovery in each case without pits or scars, excepting upon the blistered surface which presented an immense pitted scar or cicatrix. In only one case were more than five or six visits rendered.

In looking over some notes taken during Prof. H. A. Ackley's lecture upon smallpox in the year 1853, I notice that he recommended applied to the anterior chest-wall an ointment composed of croton oil, dr.  $\frac{1}{2}$ , tartar emetic ointment dr. 1. Pustulation would develop rapidly upon the chest, thereby lessening the smallpox pustules upon other parts of the body.

I was informed by the Confederate Surgeon that a short time previous to the war of the rebellion the physicians in the West India Islands pursued the blistering treatment with like results.

*975 Woodland Avenue, March 20th, 1896*

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## A Case Diagnosed as Cancer of the Vagina with the Result of Over-Medication

BY DR. D. S. HANSON, CLEVELAND

MRS. S., aged 35, married, called at my office in 1894 complaining of pain in the vagina, accompanied by a profuse leucorrhea. Upon examination I found an ulcerated surface, about  $2\frac{1}{2}$  inches in diameter, on the anterior surface of the vagina, the lower margin reaching within about one inch of the *meatus urinarius*. The surface of the ulcer was irregular, nodular and somewhat elevated, having a cauliflower appearance. The history of the case was that in September or October, 1893, she first noticed some pain and the first discharge. At that time her youngest child was about three months of age. A diagnosis of epithelioma was made.

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*Read before the Cleveland Medical Society, April 10, 1896*

The following day I called a surgeon, who confirmed the diagnosis and pronounced the case inoperable, owing to proximity of the bladder. As any severe measures would immediately involve the bladder, I concluded it best to try mild cauterization, with as thorough disinfection of the parts as possible by frequent irrigations. For the first I used a mixture of equal parts of tincture of iodine and carbolic acid; for the second, permanganate of potash and oxalic acid, of each dr. 1 to 4 ounces of water, using four drams in two quarts of warm water, three times daily. After the surface became somewhat less uneven and reduced in size, I applied crushed cranberries, kept in contact with the ulcer over night. This application was used at two different times with no benefit. In addition to these local means arsenic was given in small doses continuously for several months. After a few months, with little or no improvement, she became less regular with treatment, the result being a gradual increase of the growth or ulcer. In January, 1895, she went to St. Vincent's Hospital, where the gynecological surgeon in charge curetted off the surface and applied the actual cautery. The result was considerable relief for several weeks, when the old symptoms again began to be troublesome and frequent hemorrhages from the ulcer further reduced the patient. In October, 1895, the cautery was again used, and portions of tissue examined at this time as before showed the characteristic development of epithelioma. After this she suffered greatly with pain in the bladder and seemed to have only a short lease of life. She complained greatly of pain in the abdomen and her liver was slightly enlarged and tender, which I thought to be due to involvement of that organ in the cancerous process. There was no marked infiltration of the adjoining glands at any time. As she had received neither relief nor encouragement from anyone she was ready and willing to try anything that held out a promise of relief. Patent medicines and cancer cures of several kinds were used, until in November last, hearing that a certain doctor was effecting cures in that line she called to see him. He diagnosed the case as a simple ulcer, advised mild measures, gave douches of golden seal and witch hazel in dilute solutions, with small doses of arsenic and mezereum internally, with the result that the vagina was healthy after two months treatment, and her general condition steadily improved until today her health is as good as at any time for years.

Query! Were the four physicians that examined this case and the microscope mistaken, and the last diagnosis correct? Or was an epithelioma so rapidly and completely cured by such simple measures? My notion is that at no time was it a cancer, but an ulcer, irritated and kept open by over-medication as indicated by the title of this report.

He that through failure, learns what he has lost,  
Will ne'er forget what he gained at such cost.

*1419 Broadway*

## Tubercular Osteitis, Following a Snake-Bite

BY W. W. BRAND, M. D., TOLEDO

MRS. O., at the age of 12, was playing under a bridge and was wading in the stream when suddenly she noticed something sting her in the foot. She immediately left the place with her companions and ran home. A short time after reaching home her foot began to swell and pain her. The next day the pain was so great that she was in a delirious state for three days. The swelling increased until the foot was twice its natural size. Upon the fourth day the tension on the skin was so great that it broke and an enormous quantity of pus passed from the wound. At the time the physician in charge claimed it was a snake-bite. Two years after this, at the age of 14, she was married. In her fifteenth year her menses were established, and during the menstrual period the discharge from the foot ceased but at the close of her period it was again a running sore. Sinuses were well established at this time.

At every succeeding menstrual period the same phenomena took place. At the age of 16 she became pregnant, the discharge ceased and the sinuses closed up and had a good cicatrix. She thought her trouble with her foot was ended. After delivery of a child, the sinuses reappeared and there were running sores again as before. She had been living in this condition up to the age of 51, when the writer first saw the case. There were four sinuses radiating from the articulation of the astragalus and tibia. Some discharge was examined microscopically and found to be full of tubercle bacilli. She was emaciated, had a chronic cough, and lately had been spitting blood. Her family history was negative, except that her father had died of consumption. Operation was advised, and in May, 1894, it was performed. The astragalus, os calcis, and the articulating surfaces of the tibia and fibula were in a state of tubercular necrosis.

The limb was removed above the diseased tissue, at the junction of the upper and middle third of the leg. She made an uninterrupted recovery. Her cough disappeared, and at the end of eight weeks she was discharged. In two months I was sent for, and upon examination of the stump found it to be again a running sore. Secondary amputation was performed at the upper third of the leg. The medullary canal was curetted and plugged with gauze, and with the exception of considerable shock she has made an uninterrupted recovery.

It is now two years since she was operated upon, and the treatment seems to have made a permanent cure.

*1708 Adams Avenue*

# Cleveland Journal of Medicine

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## EDITORIAL

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### The Case of Cotell

THE Stone murders recently committed in Tallmadge present some features of medical interest. The facts briefly stated are as follows: Romulus or Romeo Cotell, a Slav, known in Tallmadge for the last few years as John Smith, about 17 years old, was until recently employed by Mr. Stone. He has been a habitual masturbator and sodomist. On the night of March 28 he went to the home of the Stones after the family had retired. He climbed a ladder and looked into the room occupied by Flora Stone and her sister. Then descending the ladder he entered the house, and with a baseball bat killed Mr. and Mrs. Stone as they lay in bed. He then went up stairs and struck Stillson, the hired man, on the head, badly injuring him, and left him for dead. Taking Stillson's jack-knife he went down stairs and hacked Mr. and Mrs. Stone with it. As he went up stairs again, Emma Stone, a daughter, came to her door and he struck her as she looked out.

At the noise, Hattie Stone, who was occupying a room with her sister Flora, came into the hall and he struck her, knocking her back into the room. She immediately locked the door. With a bicycle handle-bar he battered in the door, and found Flora crouching in a corner in her night-dress and ascertained from her that Hattie had escaped down the ladder and gone for help. He offered no violence to Flora, but left the house. The above facts are taken from his confession to the detectives who subjected him to the usual sweating process to obtain it. The base-ball bat and the mask which he wore were produced by him from the woodshed of the house where he was employed at the time of the tragedy.

The study of murder should be comparative. The question of the murderer's sanity, or rather of his accountability, is invariably raised by his counsel in the absence of a better defense, and it is only by comparing him with other murderers that one can rightly estimate his motive in committing the crime. Lombroso and his school have proved the existence of the criminal type in degenerates, physical and mental. It should be remembered however, in applying the facts discovered by Lombroso that physical signs of degeneracy are about as valuable as those of pneumonia and typhoid, usual but not invariable; their presence means much, their absence little.

So far as the newspaper accounts go, Cotell has shown no definite evidences of insanity. On the other hand, if the facts given in regard to him are true, no one can doubt that he is a degenerate of the sexual type. From the examination of him by Prof. M. M. Curtis, of Adelbert College, it appears that there are in him few, if any, of the usually accepted physical signs of degeneracy. This does not prove that he is not a degenerate morally and mentally. A well-shaped head is no more indication of a good brain than a large gold case is of an accurate time-piece. The two are apt to be associated, but some unusually finely organized and balanced brains have had somewhat inadequate lodgings, and many large and coarse vehicles of thought have roomy accommodations with a fair outside. The trouble with these degenerates is not lack of brain power. Vicious association-paths connecting brain-centers account for their vagaries. The man who must beat and trample on the object of his passion, those who, like Jack the Ripper, mutilate their victims and even eat portions of them, gratify in that way their lust in some cases even without the sexual act. The subject is not a savory one, but it is necessary to point out the fact that the lesser degrees of this form of degeneracy are not infrequent; when the more extreme forms

coexist with a marked deficiency of the moral sense they are apt to lead to the most brutal acts in the annals of crime.

The question of man's accountability for sin is general and theoretical. Whether habitual criminals, born criminals, hereditary criminals should be either punished or restrained is a question not of justice to the man, but of safety to the nation. There is no more reason for permitting a born criminal to prey on society than there is for turning a hyena loose in our homes. If insanity so blinds a man that he kills without knowing what he is doing, he is no more criminal than is a tree when it falls, but he should be permanently restrained from doing himself or any one else an injury. An excessive and perverted love of crime excuses no one. There is no use in slobbering over criminals because they are born so; they are to be pitied, but they are also to be exterminated. The laws of evolution have fortunately provided for this in a general way, but it is necessary in some cases a little to anticipate the natural order, which, though efficient, may be slow in action.

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### Execution by Electricity in Ohio

**I**T is a pleasure to again commend the State Legislature upon the passage of a very desirable law, substituting death by electricity for hanging as a punishment for first-degree murder. The law will be in effect July 1st. A few months ago we were at some pains to describe the results of an expert investigation of an execution by electricity in New York. It was clearly shown, upon most excellent evidence, that death by electricity is painless, instantaneous and absolute. Gross changes are produced in the brain which preclude absolutely all hope of resuscitation. Execution by electricity is humane, and, to all appearances, the best method of capital punishment yet devised—ininitely preferable to hanging. This State is fortunate in being the second to abolish the horrible, barbarous hanging.

With society as at present constituted capital punishment will be a necessity to its continued permanence for ages to come, but the life of a criminal should be taken as painlessly and rapidly as possible. In these particulars electricity is excelled by no other means. It is also the best agent, in that death by it can be made entirely impersonal by appropriate mechanism. Hanging depends for its success largely upon the hangman. Garroting—that most barbarous of methods in use among so-called civi-



lized nations—depends for its success entirely upon the skill of the executioner, as is clearly evidenced by recent reports from Cuba. Electricity is unquestionably the most humane means at present known for inflicting the death penalty and it is sure and speedy.

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### Sand-Filtration of Potable Water

THE abstract of a paper upon "Lake Erie as a Source of Water-Supply for the towns on its Border," by Mr. George W. Rafter, the eminent engineer of Rochester, which we are very fortunately able to present to our readers this month, is worthy of the closest attention upon the part of every physician in this city, indeed, of every intelligent citizen in all the Lake cities. Taken with the editorial upon sand-filtration from the *Medical Record*, an unanswerable argument is presented for more care in obtaining our water-supply. Sand-filtration is no longer an experiment. It is an efficient, cheap, readily operable method of purifying potable water, which should be employed by Cleveland and the other Lake cities. There can no longer be any question of its practicability and the first cost of the plant is very small as compared with the certain and great benefits derived, and the running expenses are very light.

It is in the highest degree criminal to furnish to the helpless citizens of this city a water which is certainly greatly contaminated several times a year, which may become dangerously poisonous at any time and which is never free from the suspicion of holding in suspension the germs of typhoid and other similar diseases.

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### The Laying on of Hands

RECENT events in Cleveland tend strongly to emphasize the necessity of a speedy enforcement of the Kimmell law. Two alleged physicians have been stopping at the Forest City House and holding forth at the Cleveland Theater. Their consultations at the Hotel are said to have been attended by many people who ought to know better, and the theater

where they have healed by suggestion has been crowded by people to whom much may be pardoned. A prominent oculist of the city ascertained some few days ago that his wash-woman was engaged in raising \$100 by mortgaging all of her small possessions, to hand over to these men. They agreed positively to cure a son of hers who has been at the idiot asylum at Columbus, and whose mental powers have been decidedly lacking since birth. The aforesaid oculist, after consulting with the prosecuting attorney of the county, made a call on those worthy gentlemen and intimated to them that if they accepted that particular fee he would give himself the pleasure of prosecuting them under the criminal law. They assured him that their power was very remarkable, that they could give hearing to the deaf, and sight to the blind, and raise a blister on a healthy cutaneous surface with a wave of the hand. He adventured \$5.00 on the latter operation on his own person, but his offer was declined on the ground that they were just on their way to the theater and did not wish to weaken their powers. They have not up to date either cured the imbecile or accepted the fee therefor in advance.

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A PROMINENT fig syrup company sued a competitor recently in the U. S. Circuit Court and the case has just been decided at Cincinnati by Judge Taft. The plaintiff wished its competitors enjoined from using the name "fig syrup," as that name was being advertised by them at a cost of \$250,000 annually and their competitor was reaping the benefit. The testimony showed among other things that the plaintiff's "fig syrup" was made by adding one gallon of fig syrup to 1,000 gallons of syrup of senna! Judge Taft, in deciding the case, said that as the plaintiff's business was a fraudulent one they could expect no assistance from the courts. The case was therefore dismissed.

In view of the fact, however, that the plaintiff's advertisements in the medical press specifically state that the "syrup of figs derives its laxative principles from senna," it would seem hardly fair to call the business fraudulent.

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A MOVEMENT is on foot in this city to confederate all the various scientific societies into a single organization, to be called, perhaps, the Cleveland Academy of Science. In carrying out this plan it is proposed that each society shall entirely preserve its autonomy and that

the union shall be a mere federation, the object being to obtain suitable quarters for meeting-rooms, committee-rooms and libraries. The medical societies have been represented by committees at the two preliminary meetings which have thus far been held.

This movement, if practicable, promises much for the future welfare of the medical societies, and while the difficulties in the way of the execution of the plan are very great, it is much to be wished that they will not prove insurmountable.

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**A**N interesting fact, noted elsewhere in this number, is the action of the New York Chamber of Commerce in appointing a committee to aid the Academy of Medicine to raise additional endowment for its library. When a great commercial organization undertakes to aid the medical profession in such a work it means that the importance of scientific medicine is well recognized by the business community.

The generosity of the Cleveland Chamber of Commerce to the Cleveland Medical Society for the past two years is well known to most of our readers and is certainly very highly appreciated by the members of the Society. It is also the hope of the profession that this friendly spirit on the part of Cleveland's active commercial organization will lead to even better things for the profession of the city in the near future.

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**W**ITH the advent of warm weather the bicycles have come out like frogs in Egypt. One who has watched the army of wheelers struggling for possession of the small amount of asphalt pavement available is drawn to the conclusion that bicycles are something more than either a vehicle or a passing fancy. I believe the secret lies in one word, balancing. There is something of fascination in unstable equilibrium, whether on a trapeze, a wheel or an ordinary drunk. It is not for nothing that we call the exhilaration of a spin on the bike intoxication. The wheel itself has the speed of a horse, without the appetite. It gives better exercise than pounding a piano, and is not so hard on the neighbors. It has all the delights of skating without the frost-bites. It has one fault; it is a little too alluring.

One or two remarks may be in order to those who have not profited by experience.

The kangaroo position is about as healthy as it is graceful and should be avoided.

The body should not be supported entirely on the prostate gland; get a good saddle and give the nates their share of work.

It is not necessary to emulate the locomotive; the motor car goes fast enough.

The century run conduces not so much to health as to vanity.

## Our Toledo Letter

**A**T a recent meeting of the Toledo Medical Association it was decided to start a medical library. A large number of books and periodicals have been donated and the committee has about \$500 in its treasury.

Within the last few months there has been an epidemic of typhoid-fever in the city and twenty-seven of the cases were along the route of one milkman. The Board of Health caused an examination of the milk, and of the wells at the dairy. The report was negative. Sanitary officers also examined the barn and sheds, also the cattle, and the report was also negative. There is a peculiar coincidence in these cases which would warrant a further and more thorough examination.

Dr. Beardsley of Ottawa was the first man in the field, pushing his claims for indorsement, as a member of the Medical Board from this section of the State. His support was not as enthusiastic as he might have desired. We mention this not as a reflection on the standing of Dr. Beardsley, nor for lack of good-will upon the part of the profession in this section, for he is most highly respected, but we merely wish to emphasize the point that in the future, local and district medical societies should nominate a candidate for such positions and then stand by the nomination with all the influence they can possibly command.

The Commencement Exercises of the Toledo Medical College were held March 31, 1896. There were nineteen candidates for the degree in medicine.

There is at present a smallpox scare in the city, caused by the arrival of some emigrants from Baltimore, who were allowed to land from the steamer Illinois, which had some well-developed cases of smallpox aboard. The blame is placed upon the quarantine officials for not holding the vessel in quarantine, and upon the Pennsylvania railroad officials for transporting the already infected emigrants.

Much credit is due our health officer for the prompt removal of the emigrants to the contagious hospital immediately upon their arrival in the city.

Dr. Hubbard reports the case of a child, 12 months old, who had swallowed a kernel of corn which lodged in the trachea. The corn was in the trachea five weeks at the time the case was seen by Dr. Hubbard. Diagnosis was in doubt and the delay by the family physician was unavoidable. The child developed croupous symptoms and when it cried the air was completely shut off by the corn forcing itself against the vocal cords.

Upon examination of the trachea and the bronchi during normal respiration, the kernel of corn could be plainly heard traveling from the larynx down to the first division of the bronchi. The corn having swollen, it was too large to be coughed out, and as soon as diagnosis was made operative procedure was resorted to.

A pair of rat-toothed forceps was passed into the trachea and the kernel of corn grasped during expiration. Even after it was in the firm grasp of the forceps considerable manipulation was required before it could be removed.

## Purification of Drinking-Water by Means of Filtration

THE report of the Massachusetts State Board of Health for the year 1894 contains some very interesting and important facts upon all these points.

For the past seven years the board has maintained an experimental station at Lawrence for the sole and express purpose of testing the efficacy of filtration of water to purify it and render it fit for household purposes. The water tested was that of the Merrimac River, which is lined from source to mouth with manufacturing towns, and which may be taken as a fair sample of river water contaminated with a considerable amount of organic matter.

The filters were of all sizes and thicknesses, from those a few feet square and ten inches in depth to the large filter covering two and one-half acres, through which the water supplied to the city of Lawrence has been filtered since 1893.

Chemical and bacteriological examinations were made weekly and sometimes daily of the water of ingress and egress. Sand of different sizes was used, and the filters were run both intermittently and continuously.

The results of this careful and painstaking investigation, extending over a number of years and every source of error being eliminated, are both astonishing and gratifying.

From a bacteriological standpoint they prove that a properly constructed and properly managed filter will remove from 98 to 99.84 percent of the ordinary bacteria in water, and that if such bacteria as the bacillus prodigiosus, which is very similar to the typhoid bacillus, be added to the water in varying proportions, the filter will remove from 99 to 99.993 percent. The organic matter in solution is greatly diminished and the water is chemically purified.

Moreover, the efficiency of the filter instead of diminishing increases with age and use, owing to the formation of a gelatinous coating about each grain of sand, which serves to entangle the bacteria in their progress.

The rate of filtration may reach five million gallons daily per acre of filter without impairing the efficiency. If the surface-clogging is properly removed there will be no appreciable difference in the quality of the filtered water during or after the process of removal.

Finally, the cost of construction and maintenance of such filters is not so great as was supposed, and is not to be compared with the benefits derived from their use. The one which has been in successful use in the city of Lawrence proves that the plan is practicable in supplying cities with potable water. It seems to us that the knowledge derived from these experiments should be spread abroad and the attention of the municipal authorities called to them.—*Medical Record*.

OFFICIAL PROCEEDINGS  
OF THE  
Cleveland Medical Society

ADJOURNED MEETING, MARCH 20th, 1896

*The President, DR. J. E. COOK, in the Chair*

**Report of Cases and Exhibition of Specimens**

DR. W. E. WIRT

*Acute Osteomyelitis, with Exhibition of Specimens*

The patient, a boy of ten years old, living in a small town in Wayne County, Ohio, while at play in a school-yard, fell, striking his left tibia at the upper epiphysis, and injured himself quite severely. After a hard cry he paid no more attention to the injured limb until bed-time, when he complained of pain just above the knee. His mother said he slept none that night. The next day he felt no better, but was up and about the house. He got no sleep the following night, and the next morning the family physician was called. From that time the boy remained in bed, had a high temperature, great pain in the tibia, loss of appetite, rapid emaciation, but at no time was delirious. Two physicians were called in consultation and concluded that the boy had tubercular osteitis of the head of the tibia, or as it is commonly called, white swelling of the knee-joint. Two of the physicians were in favor of amputation; the third objected. Under these conditions I was sent for to see the case. Two uncles of the boy had died of consumption. I found, however, that on the fifth day of the disease an abscess had formed, which, when opened, discharged considerable pus. The formation of the pus had been too rapid for tubercular disease, as in addition the whole tibia was involved. The skin was dusky and mottled in appearance, with considerable edema of the limb, and numerous openings in the skin from which pus was discharging. I made a diagnosis of acute osteomyelitis. A probe showed that the tibia was fairly riddled. The knee-joint was completely destroyed, the bones moving upon each other as in a sack. I recommended amputation. If a diagnosis had been made earlier the treatment would have been to cut down through the periosteum to the bone and to relieve the pressure of the blood from below, and if this had not given relief, to have drilled and chiseled openings into the bone. The specimen before you shows very well the green pus found in these cases.

## Program

DR. G. O. BUTLER

*Local Treatment of Smallpox*

This paper will be found on page 215 of this number of THE JOURNAL

DR. W. T. HOWARD, Jr.

*Amebic Abscess of the Liver.*

DR. HOWARD said in part: I have seen several cases of amebic abscess of the liver in Cleveland with Dr. Hoover. In dysentery the amebae get through the walls of the intestines and are carried by the peritoneal current to the surface of the liver. One finds amebae also in the small veins of the intestines. They cause abscess deep in the liver. Abscesses are also sometimes found, especially in acute cases, spread out through the liver along the portal system. The most common seat of abscess is in the upper surface of the right lobe of the liver. It may be in the quadrate lobe, and is not very common in the left lobe. The abscesses may be single or multiple. They may vary greatly in size, involving the whole lobe of the liver. Not uncommonly one finds the whole of the right lobe of the liver involved. The abscess contains a quantity of gelatinous material. The walls are soft. In chronic abscess of the liver the pus is perfectly characteristic. It is composed of a sort of necrotic tissue; beneath this there is something of a gelatinous appearance, and beneath that is thick, firm, fibrous tissue. The process in the liver is very much the same as it is in the intestines. There are the same breaking down and modifications of the tissues without any inflammatory action. The amebae seem to have a peculiar necrotic effect upon the tissues. In the smaller abscesses one always finds amebae; in chronic abscess, especially in aspirated pus, they are often difficult to find, but if one makes sections of the walls or examines cells from scrapings one always finds amebae. I have here some drawings of the ameba coli. One shows an ameba sending out pseudopodia; within the amebae are numerous vacuoles. The nucleus stains a deep red. The vacuoles are only tinted. The first one to see the ameba coli in this country was Dr. Osler, of Baltimore. I think I was the second one to see it because I looked over his shoulder. Since then numbers of cases have been reported by Osler's assistants. Cases have been reported in Philadelphia and Texas. The English do not seem to have risen to the importance of the disease and the beautiful opportunities they have of studying it. The ameba as you usually see it varies from 10 to 50 micromillimeters in diameter. It moves sometimes very sluggishly and sometimes quite rapidly. There are two kinds of motion, a forward motion, in which the whole body seems to move, a rolling motion, and besides that a motion which is characterized by the sending out of pseudopodia. Once seen it can always be recognized afterwards. The ameba is pathogenic to cats.

DR. C. F. HOOVER

*Amebic Abscess of the Liver.*

The chief diagnostic signs of hepatic abscess originate from involvement of the peritoneum, the diaphragm, and the phrenic nerve. When the peritoneal covering of the liver shares in inflammatory process there is severe

pain which is increased by the respiratory act or by pressure in the hypochondrium. We also may detect a friction during the respiratory excursion of the liver both by palpation and auscultation. The location of the friction enables one to locate the point for exploratory puncture. A friction sound heard over the hepatic area, when a diffuse peritonitis can be excluded, nearly always is due to either an abscess or a gumma.

Through the agency of the phrenic nerve we have the referred pain to the shoulder, scapular, trapezius and cervical regions, and also the external end of the clavicle. The pain may be severe or merely a sense of fullness, pulling or tension. An ascending neuritis may occur through the same agency as has been seen in atrophy of the deltoid muscle following an hepatic abscess. *Tussis hepatica* and hiccough also originate through the phrenic nerve. When a myositis of the diaphragm supervenes diaphragmatic breathing is largely sacrificed, atrophy of the diaphragm results, the diaphragm no longer resists the normal elasticity of the lungs, which retract, the diaphragm and liver following upward. It is for this reason that the liver in tropical abscess is seemingly enlarged in an upward direction. It is displacement upward not enlargement upward. For this same reason the respiratory excursion is lost or diminished, the base of the lung, or rather where the lung should be, is dull, with absence of vocal fremitus and respiratory sounds, so that empyema or pleurisy with effusion is strongly simulated. One cannot exclude an infraphrenic location of the pus in case air should rush in through a canula or surgical opening during inspiration and pus flow out during expiration, because when the action of the diaphragm has been sacrificed and only costal breathing is present, the pressure within the cavity of an hepatic abscess is diminished during inspiration by the elevation of the ribs and increased during expiration by the ribs sinking back. The retraction of the lung, before perforation of the diaphragm by the abscess occurs, deprives it largely of its respiratory value so that when perforation into the right thoracic cavity does occur, the patient is little worse off than before.

Treatment of hepatic abscess surgically is the only means that has offered any good results with the single medical exception of the plan of Wm. Stewart, of the English service in India, who puts the patient to bed, giving as much as twenty grains of chlorid of ammonium four times a day. Under this treatment there was not a single death from liver abscess (during three years service) in an English regiment in India. During the preceding four years there were twenty-eight deaths from tropical abscess in the same regiment.

### Discussion

DR. JOHN H. LOWMAN: The papers we have just heard are deserving of praise. There is much to be said on the diagnosis of abscess of the liver. The fact that so few cases come under our observation proves that many of them have not been discovered. I do not recall an instance in my practice where the diagnosis has passed undisputed where two or more men have seen the case, and that alone would make this discussion timely. That Dr. Hoover has in so short a time found six cases shows that he has let no guilty liver escape. An inactive solitary abscess will always be a *terra incognita*. Repeated chills and paroxysms of fever that do not yield to quinin should always be regarded with grave suspicion, and abscess of the liver anticipated.



QUARTERLY MEETING, MARCH 27, 1896

*The President, DR. COOK, in the Chair*

DR. N. P. DANDRIDGE, OF CINCINNATI

read by invitation a paper on

*Amputation in Diabetic Gangrene*

The paper appears in full on page 201 of this number of THE JOURNAL

**Discussion**

DR. C. B. PARKER: I am sure we are all very much obliged to Dr. Dandridge for presenting this subject to us in so able a manner. The older writers did not advise amputation in diabetic gangrene as their results were so disastrous; partly because they misjudged the position at which a successful amputation could be made; partly from their want of knowledge of antiseptic methods. It is exactly in gangrene that antiseptic treatment gives the best results. Simple incised wounds often heal by first intention without antiseptic care; but it is in the treatment of contused and lacerated wounds in which a certain amount of tissue is dead or dying and must be separated that the strict antiseptic methods of treatment are necessary, and, when carried out without the intervention of suppuration, offer a real test of one's mastery of the antiseptic technic. Gangrene is not necessarily associated with putrefaction. An aseptic gangrene pursues a physiologic course in which absorption of all material which can be of service in the economy takes place and only the perfectly dead and utterly useless residue is cast off without producing any deleterious effects upon the body generally.

We might add to the conclusions that were given tonight that whenever the general practitioner meets a case of diabetic gangrene it is his duty to treat it with the most rigid antiseptic precaution. So far no specific germs have been discovered, although suspected, for traumatic gangrene or phagedena. The paper leaves to the patient a fair hope of recovery. I believe in ordinary cases the amputation should be done above the knee.

DR. D. P. ALLEN: Cases of gangrene in connection with diabetes have not been very frequently observed. In the discussion of a paper read before the Philadelphia County Medical Society by Wm. Hunt and participated in by many men of large experience, this point was well brought out. According to the report in this paper, T. G. Morton had seen thirteen cases, Agnew six, Hunt five, Osler one, Ashurst one, Packard and Keen none. Other names are reported, but the number of cases seen by all the men cited (thirty-two in number), amounted to only sixty-four cases. Seven men of large experience had not seen a single case. We may thus be sure that the disease is far from common. The relation which diabetes has to gangrene is in my mind somewhat subsidiary. The other conditions common to senile gangrene are, however, as far as my observation goes, always present, the most common of them being the calcareous condition of the arteries with diminished caliber and consequently diminished flow of blood. That diabetes is not the primary cause of gangrene may be illustrated by two sets of cases. Diabetes in its most exaggerated form occurs in young children with no known tendency to gangrene. The form of gangrene called noma also occurs among children without diabetes.

On the other hand, a patient with marked diabetes has recently been under my care, in consultation with Dr. J. P. Sawyer, for large perirectal abscess. The abscess was opened widely, and healed more rapidly than any similar abscess in a non-diabetic patient which I have ever seen. Here a sloughing wound, associated with diabetes, but with undisturbed blood-supply, healed rapidly.

Often, perhaps, diabetic gangrene occurs in which the diabetes is overlooked. A short time ago I treated a case of gangrene of the foot, in consultation with Dr. Lueke. The urine showed a specific gravity of 1.011. Ordinarily one would have thrown the urine away without examining for sugar, but sugar was found in every specimen examined.

I might mention another case which is perhaps known to many members of this Society. A man prominent in the affairs of the city was known to have diabetes and still he succeeded in placing large policies for life insurance. I saw him one night sitting on a sofa at a public assembly, and asked him why he sat there, and he said because he had stubbed his toe and it was paining him. Shortly afterward I was called to see the man in consultation with Dr. P. H. Sawyer, and he had symptoms of beginning gangrene, limited in extent. Amputation was advised but declined. The case made trouble for a number of months. It seemed for a time that the wound would heal, but by some over-exercise the process was re-established, and suppuration gradually extended along the lymphatics upward to the thigh, and the man finally died. The patient first spoken of, whose urine had a specific gravity of 1.011, had, when I first saw him, gangrene of the great toe, but several times before this he had had small ulcerations of the foot, resembling slight attacks of *mal perforant*. The toe was removed, but in spite of a perfect drainage the gangrenous process began to extend. We then amputated about the middle of the leg. Great care was taken in antiseptic precautions, and although the healing was somewhat delayed, the patient has as perfect a stump today as you will often see.

There is no question of the correctness of the conclusion reached by Dr. Dandridge, that amputation for gangrene of the foot should be made high up. It will be noticed, however, that my case healed perfectly after amputation below the knee, and it would seem proper that the point of amputation might be varied according to the judgment of the surgeon in the individual case.

The point made by Dr. Parker that the flaps should be well nourished is of great importance.

There is at the present time at Charity Hospital an old colored man who has slight gangrene of the toes. He says that he froze his toes. You will see him tomorrow in the clinic to be held by Dr. Dandridge, and will find a most marked case of calcareous degeneration of the arteries. Although the case is not associated with diabetes, it may be of interest in connection with this paper in demonstrating the condition of the arteries found in senile gangrene, whether of the diabetic or non-diabetic form. The radial artery is very thick, and rolls under the finger like a pipe-stem. In the cases of diabetic gangrene, which I have mentioned, the arteries were very calcareous, and their caliber was greatly diminished, and the amount of blood which could be transmitted through them much decreased.

In the discussion of this subject the question arises in my mind whether in all cases of beginning gangrene of the foot, where diabetes is present, it

would not be wiser to proceed at once to amputation, rather than to take the chances of spontaneous separation, as has formerly been advised.

In my opinion the dangers of operation in the presence of diabetes are less than of the extension of septic infection, if high amputation is not performed.

DR. LOWMAN: I have been much interested in Dr. Dandridge's paper, and am indebted to him for what he has said. I wish to make a suggestion regarding the preparatory treatment of a patient who is about to undergo an amputation of the leg for gangrene due to arteriosclerosis. The doctor has shown that the flaps often die on account of the narrowed vessels. Cannot nitroglycerin be used here with good effect? This drug does undoubtedly dilate the vessels and lower the tension. Moreover, it is not temporary in its effects, as is so often stated. It is not fleeting, or, if fleeting, its effects are often permanent. I recall a case of so-called neurasthenia attended with insomnia and hysteria, in which the arteries were sclerotic and the heart hypertrophied. All the nervous symptoms disappeared in a few days after the use of nitroglycerin. Undoubtedly in this case cerebral anemia was relieved. In another instance very tense sclerotic arteries were relieved by the same drug in a short time. Not infrequently prominent serpentine temporals will subside in a day. Why not then give nitroglycerin to a diabetic suffering from gangrene due to arterial sclerosis, in the hope of dilating capillaries, or at least of flushing the capillaries, and aiding thus the nutrition of the flaps after an amputation?

The operation itself produces a spasm of the already contracted vessels in a sclerotic case, and this spasm may be at least mitigated by treatment. The sclerotic portion of the artery is of course not affected, but the healthy part is affected, and the peripheral circulation is markedly increased. It seems to me that previous treatment with the nitroglycerin in these unfortunates is reasonable, and that it vouchsafes some hope in even desperate cases.

DR. G. D. UPSON: Continued errors of diet are undoubtedly productive of disturbances of nutrition, and impaired nutrition favors gangrene. There are no distinctive blood changes other than an increase of white corpuscles and an excess of sugar, which causes inflammation of the nerves and is very apt to produce endocarditis. It is unusual to see cases of diabetic gangrene in young people; thus it is reasonable to conclude that the atheromatous or sclerotic condition of the blood-vessels occurring in middle or old age is the cause of the gangrene, and that the diabetes is merely a complication. The excretions of the skin are local irritants and favor the more rapid development of gangrene complicated with diabetes.

Cases of gangrene die from exhaustion or septicemia and the prognosis is usually bad. So far as the clinical course is concerned diabetic gangrene may be considered the same as senile gangrene, and its treatment should be governed by the character of the gangrene. The general health must be supported and the diabetes treated. The inflammation is to be treated on general surgical principles by rest and moderate elevation; as a local application I know of nothing so good as Goulard's wash, the solution of the subacetate of lead.

When only one or two toes are affected it is best to wait for the line of demarcation, and if extension occurs, to amputate; compression should be used rather than Esmarch bandage, and on account of the increased tendency to wound-infection in diabetes the surgical rule to operate in healthy tissues

holds good; thus, in cases in which extension occurs in spite of local and constitutional treatment, amputation should be performed above the knee in the lower third of the thigh, where usually well-nourished flaps may be obtained. I have seen two cases in which the gangrenous inflammation was treated as outlined with the result that only one and two toes sloughed off, leaving a perfectly good foot.

**DR. C. A. HAMANN:** Councilman has recently suggested the diminished germicidal powers of the blood-serum as a possible cause of diabetic gangrene. In an extensive series of cases reported by Heidenhain from Küsters clinic there were some thirty operations in all upon 25 cases. In most of these cases careful examinations of the blood-vessels were made and it was shown that almost invariably sclerotic changes were found in the tibial and popliteal arteries, an additional fact confirmatory of the statements made that the amputation is best performed at the lower third of the thigh. I have seen but one case of diabetic gangrene. In this case an amputation was made at the lower third of the thigh, and although there was marginal gangrene of the flaps recovery ultimately ensued.

**V. Bergmann** makes it a rule to amputate at the lower third of the thigh in beginning diabetic and senile gangrene. The flaps are not sutured at the time of operation, but if after a delay of three or four days it appears that gangrene does not attack the stump secondary suturing is made use of.

**DR. G. S. SMITH:** I saw a rather instructive case of diabetic gangrene in the Rhode Island Hospital, in the practice of Dr. Mitchell, last winter. The man came in with gangrene of one of the toes. We allowed the line of demarcation to form and the man finally left the hospital apparently well, but returned to us six weeks later with most of the foot involved, and at that time his condition was such that we did not dare to operate. He rapidly failed and died in about four weeks. It would be interesting to know whether amputation in the first place would have saved or prolonged his life.

**DR. O. T. THOMAS:** The question arose in my mind, when Dr. Dandridge was reporting his case, as to whether or not the long-continued use of opium prior to the operation had not had some deleterious effect on the action of the kidneys, thus giving the uremic condition. It seems to me it might be a practical point to consider if the opium treatment can not be delayed, and diabetic treatment alone continued.

**DR. J. P. SAWYER:** In reference to the desirability of early amputation it is well to bear in mind that the member is crippled by the endarteritic process, and slight injury or over-exertion promptly puts the patient again in the same danger from which he has just escaped. This is emphasized by some of the cases mentioned here this evening.

The non-operative management of gangrene in arteriosclerotic conditions, so far alluded to, has been largely by poultice or by application of lead solution or some similar local remedy. In a case in the City Hospital four or five years ago, in which the patient had already suffered amputation of one foot, the method of Brodie was put into use, namely, moderate elevation of the foot, wrapping thoroughly in lamb's wool, maintaining dry heat and carefully attending to the cleansing of the sore. Cicatrization occurred rapidly and so far as I know the patient remained well for a considerable time. I have now seen three cases not complicated with diabetes in which

it has worked well, and in one case of diabetic gangrene it also seemed to favor very well the recovery of the patient. In cases where operation is objected to I believe it ought to be used, rather than moist heat and moist dressings.

DR. CHARLES GRAEFE, of Sandusky: If it were permitted to even hint at a criticism of the able paper it would be to question the recommendation of amputation through the knee-joint, leaving the condyles to act as irritants and to be in the way of the perfect fitting of an artificial leg. I believe, by all means, that amputation should be made above the condyles if the patient is expected to use artificial means of locomotion.

DR. G. W. CRILE: I remember once in the hospital my senior house officer amputated a man's leg in the lower third on account of a very severe accident to his foot. This case was known to be a diabetic and the flaps did not repair although primary union was sought for. After some time tetanus made its appearance and the patient died in four or five days. I remember another case—a fractured femur in a diabetic subject. The bone did not unite, although the conditions were favorable for union. The patient died from the combined effects of the fracture and the diabetes.

In a case of laparotomy in a diabetic subject, I remember the walls of the abdomen were repaired very slowly, and at one time it seemed as though they would not repair at all, but after a time repair was completed.

DR. DANDRIDGE (Closing Discussion).—I feel very much gratified that my paper has elicited so very interesting and valuable a discussion. The suggestion that Dr. Lowman has made in regard to the use of nitroglycerin in arteriosclerosis is, I think, very valuable. Generally in diabetic gangrene treatment cannot be long continued because the gangrene progresses so rapidly that it is necessary to act promptly before the occurrence of advanced septic symptoms. The suggestion which was made, that possibly the opium might have had a deleterious effect on the uremic symptoms, and have intensified them is one which I confess occurred to me before. It is possible in these cases that persistent use of morphin may possibly have something to do with developing uremic trouble. It is very necessary to warn all cases of diabetes against exposure to cold and to any injury. One of the cases which Dr. Allen reported, was a case in which gangrene occurred after slight contusion of the toe. Dr. Parker spoke of the possibility of avoiding septic conditions when there was a diminished resistance to the invasion of germs. An important example of this is seen in case of a crushing injury of the hands or feet. We want more knowledge upon the exact cause of diabetic gangrene and upon the exact reason why in certain cases coma develops and why in other cases it does not. The degree of arteriosclerosis is probably an important factor. Those cases in which there continues a free elimination of urea are not so likely to develop serious or fatal symptoms of the operation.

I desire to express my appreciation, Mr. President and gentlemen, of the very kind reception accorded me, and I feel that this has been one of the pleasantest and most profitable meetings of a medical society that I ever attended.

SPECIAL MEETING, APRIL 3, 1896

PROFESSOR D. C. MILLER OF THE CASE SCHOOL OF APPLIED SCIENCE  
read a paper on

*The Röntgen X-Rays with Experiments*

PROFESSOR MILLER said that the experiments with the Röntgen rays have been carried on at the Case School for several weeks. The main object has been to secure good photographs of the human skeleton in a living subject and to increase the practical efficiency of the apparatus. The experiments of Röntgen are a continuation of those made by Lenard in 1893. The rays are not cathode rays, but differ from them in that they are not deflected by a magnet, nor by any known substance in passing through it. The Crookes' tubes which are used are simply the old Geissler tubes much better exhausted. The ordinary incandescent bulbs have a pressure of possibly one ten-thousandth to a hundred-thousandth of an atmosphere. The Crookes' tubes must have a pressure not exceeding one millionth of an atmosphere to take a successful picture. In order to get the required amount of exhaustion the Sprengel pump must run at least 24 hours.

The lantern slides shown by Prof. Miller were wonderfully clear and very interesting. The arm which he showed was photographed with an exposure of 20 minutes. It was held by bandages to the plateholder which was supported in an inclined position on a special stand. The usual plateholder slide of hard pasteboard was between the hand and plate. The Crookes' tubes were placed at a distance of 12 inches above the wrist. Rapid plates were used and developed in the usual way with eikonogen and hydrochinon developer. A great deal of detail appears plainly during development, which disappears in the "fixing" process. A photograph showing the bones of the fingers has been made with ten seconds' exposure, the tube being two inches above the plate.

The bones of the entire arm including the shoulder-joint, and of the foot have been satisfactorily photographed. Attempts have been made to photograph the chest and head with exposures of one hour in each case, the tube being eighteen inches from the plate. The resulting negatives show a surprising amount of detail, which is too faint for satisfactory reproduction. The chest picture shows eight ribs on each side of the spinal column, a dark streak in the latter corresponding to the spinal cord. Under the region of the heart the ribs do not show, indicating that the heart is more opaque than the lung tissue. The collar-bone is prominent, while the details of the shoulder-joint can be seen. The picture of the head shows the following details: The spinal column in the neck, the jaw-bones, with teeth and spaces where several are missing, the nasal cavities, the thickening of the bone showing clearly the outline of the ear, the thin places at the temples, the floor of the brain cavity, and the ragged edge where bone and cartilage join in the nose. These pictures, though of little surgical value, are very interesting experimentally. Some of the negatives clearly show the ligaments connecting the bones at the joints, while none have so far shown any blood-vessels or nerves.

Bullets have been located in the hands of four men, and numerous cases of hands injured by machinery and of deformities have been examined, the

exposures varying from two to twenty minutes. Some very valuable and interesting pictures of diseased arm bones and of fractures of the arm have been taken. In one case four inches of the arm bone had been removed five years ago, and the extent of the disease is clearly shown. Views of the fractures where the ends of the bones are not in apposition, are of value to the surgeons. These photographs are taken through bandages, splints and silicate of sodium casts without hindrance.

A most interesting study has been the position of the various small bones of the wrist in different positions of the hand.

The paper was discussed in an interesting way by Professor Churchill of Oberlin, and Dr. G. C. E. Weber and Mr. Frank Wing, of this city.

#### REGULAR MEETING, APRIL 10, 1896

*The President, DR. COOK, in the Chair*

Meeting called to order at 8:00 o'clock.

The proposed amendment to the by-laws, establishing weekly meetings of the Society, instead of bi-weekly, after full discussion, was laid on the table.

The amendment in regard to the composition of the Council (that it should include the chairman of the Board of Censors instead of the full Board) was lost.

A motion was carried authorizing the committee to secure the publication of the amended Constitution.

Attention was called to the date of meeting of the State Society, at Columbus, May 27-8-9, and a letter read in regard to the attractive program prepared.

It was decided that a person be appointed to take and return the diplomas of those who wished to send them to Columbus for registration.

DR. HAMANN set forth the defects of the present law in this State regarding the supply of anatomical material, stating that a bill, endorsed by the Cincinnati Academy of Medicine, had been introduced in the Legislature, similar to the law which had proved satisfactory in Pennsylvania, and asking the assistance of the Society in its behalf. A motion was carried that the Society give this bill its support.

It was moved and carried that two gentlemen be appointed to represent the Cleveland Medical Society in the preliminary organization of a federation of the scientific societies of Cleveland and vicinity. The President appointed Drs. Rosenwasser and Straight.

The President appointed a building committee (provided for at a previous meeting) consisting of Drs. HUMISTON (Chairman), PARKER, ROSENWASSER, ALLEN and CORLETT.

DR. TUCKERMAN brought before the Society the matter of the appointment of professional men for political reasons, rather than competency, and presented resolutions which were referred to the Committee on Legislation with instructions to report to the Society.

#### Program

THE PRESIDENT: All will regret that we are to be disappointed in a feature of our program. The secretary has received a letter from Dr. Parker.

(The secretary here read the letter referred to, stating that owing to sickness in his family, Dr. Parker had been delayed in the preparation of his paper, and would be compelled to ask the indulgence of the Society.)

DR. D. S. HANSON

*A Case Diagnosed as Cancer of the Vagina with the Result of  
Over-Medication*

This paper appears on page 216 of this number of THE JOURNAL

Discussion

DR. G. A. ORWIG: I thought I recognized that case when I saw the title, because I made the same mistake. About a year ago, or a little less, this patient came to me for examination. I had been her physician in former years. Occasionally during the past fifteen years I have been called to see and treat her.

I must certainly say that I do not blame the doctors for making the mistake they made, because this ulcer had all the appearance of an epithelioma. The woman had the general cancerous cachexia. I must say she had had that appearance for a number of years. At that time she came under my care for a miscarriage. She was then anemic. At that time there was no evidence of ulceration or anything of that kind. She had had a number of healthy children.

DR. L. B. TUCKERMAN: All of this goes to show that while the microscope never is mistaken some men are sometimes mistaken with the microscope. Malignancy is a clinical fact, it is not always an anatomical condition. The microscope may determine once in a while that a growth is very malignant, and it may refuse to behave malignantly. It may determine that a growth is benign, and yet, in spite of the microscope, the growth will go on and behave very malignantly. This puts me in mind of a remark made by Jay Gould to a friend of mine. He said that he did not expect to be right all the time. If he was right three times out of five he was on the safe side.

We learn a great deal from a case of that kind. I remember one case where I operated, *secundum artem*, for a lacerated cervix. It was a badly lacerated cervix, but the patient was well before the operation. Four weeks' rest in bed had cured her.

DR. C. A. HAMANN: With regard to the use of the microscope to confirm clinical diagnosis there are certain facts to be borne in mind. In the first place the position or the situation on the tumor from which the mass is removed for examination is of importance. As an illustration of this might be mentioned the case of the late Emperor Frederick. Virchow pronounced the case malignant. It is probable he never saw a proper portion of the tumor, and hence his diagnosis was at fault. I believe that is the accepted explanation of that case.

I would mention also a case I had an opportunity of seeing. A man presented himself with a large ulcerating tumor of the upper portion of the thigh. A portion from the surface of this was sent to a pathologist. He made the diagnosis of round-celled sarcoma, and recommended amputation at the hip-joint. It was found, upon more careful examination, that that tumor was lipoma.



**DR. H. W. ROGERS:** I am not a pathologist, and make no pretensions in that line of work, but I do know this to be a fact, that it is an extremely hard matter for a pathologist to decide between granulation tissue and cancer.

Watson, in his practice of medicine, called attention to the same fact. It has been called attention to in very many instances. I have in mind a case in which a malignant tumor was diagnosed and operation performed, removing a certain portion of the tumor. Finally it developed into a tuberculous growth.

**DR. HANSON:** A gentleman asked me why I used cranberries in that case. I had heard a number of times of the use of cranberries in similar cases, and one man who had been using them claimed he had very fine results. I hardly knew what to use and tried that.

I one time heard a very competent physician say that he oftentimes started out in the morning thinking he would go over all his chronic cases and examine them just as if he were a consulting physician, and try to get his preconceived notions out of his head. I think if I had done so with this case it would have been better. There was no inflammation, but I felt certain of the diagnosis. The tissue was passed around before the students of the college. The specimen was not from the surface, it was probably as deep as any curettage ever is. But the fact that it continued for that length of time without extending to other organs ought to have been conclusive evidence that it was not of that nature.

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## Ohio State Medical Society

**Fifty-First Annual Convention, Columbus, May 27, 28 and 29, 1896**

MEETINGS TO BE HELD IN STATE HOUSE

**P**RESIDENT, Dan Millikin, M. D., Second and Ludlow sts., Hamilton. Vice-Presidents: J. H. Goss, M. D., Lancaster; William H. Humiston, M. D., Cleveland; John A. Murphy, M. D., Cincinnati; B. M. Ricketts, M. D., Cincinnati. Secretary: Thomas Hubbard, M. D., 205 Ontario street, Toledo. Assistant Secretary: H. M. W. Moore, M. D., 243 E. Town street, Columbus. Treasurer: James A. Duncan, M. D., 1107 Broadway, Toledo. Committee of Arrangements: J. F. Baldwin, M. D., Chairman, 112 North Fourth street, Columbus; E. B. Fullerton, M. D., Columbus; R. Harvey Reed, M. D., Columbus; C. O. Probst, M. D., Columbus; Starling Wilcox, M. D., Columbus.

The Ohio State Medical Society will hold its annual convention May 27, 28 and 29, in Columbus. Its sessions will be held in the State House. The Board of Registration and Examination will be in session during the convention, and as this is within the lawful time, diplomas can be registered. A practical surgical demonstration of the X-Rays will be one of the features of the program. Special rates are made by hotels and railroads. On Thursday evening after an address there will be a banquet. A list of papers to April 25 is appended.

## List of Papers

Lecture on Röntgen Rays—A Practical Demonstration of the Process of Making Radiographs, with Lantern Slide Illustrations, by Prof. Benj. F. Thomas, Ph. D., O. S. Univ.

Jas. T. Whittaker, M. D., Address in Medicine: "The Neuroses of the Stomach."

Dan Millikin, M. D., President: Annual Address.

R. Harvey Reed, M. D., Columbus: "A Review of the Results of the Author's Method of Anchoring the Kidney."

John A. Thompson, M. D., Cincinnati: "Acute Purulent Inflammation of the Middle Ear."

Thomas W. Jackson, M. D., Akron: "Extensive Skull Fracture with Unusual Symptoms. Operation; Recovery."

William Thomas Corlett, M. D., Cleveland: "The Present Status of Vegetable Parasitic Diseases of the Skin."

N. Stone Scott, M. D., Cleveland: "Seminal Vesiculitis."

E. C. Brush, M. D., Zanesville: "Diet in Typhoid Fever."

Max Thorner, M. D., Cincinnati: "Serious Complications of Suppuration of the Middle Ear."

J. S. Halderman, M. D., Zanesville: "Contagion and Diagnosis of Scarlet Fever."

W. H. Humiston, M. D., Cleveland: "A Method of Preventing Thirst after Celiotomy, with a Study of the Urine."

C. R. Holmes, M. D., Cincinnati: "The Accessory Cavities and their Relation to the Eye. Report of Cases and Presentation of Specimens."

J. F. Baldwin, M. D., Columbus: "The Technique of Abdominal Supravaginal Hysterectomy."

J. C. Oliver, M. D., Cincinnati: "The Radical Cure of Inguinal Hernia."

S. S. Halderman, M. D., Portsmouth: "Antitoxin in the Treatment of Diphtheria."

H. D. Hinckley, M. D., Cincinnati: "Pathologic Conservatism."

M. Rosenwasser, M. D., Cleveland: "Phlegmasia Alba Dolens following Laparotomy."

Jas. T. Whittaker, M. D., Cincinnati: "Some Points in the Treatment of Tuberculosis of the Lungs."

Hunter Robb, M. D., Cleveland: "On the Causes and Mechanism of Retroflexion and Retroversion of the Uterus."

J. E. Fackler, M. D., Versailles: "The Treatment of Diphtheria."

B. L. Millikin, M. D., Cleveland: "Some of the Accidents of Cataract Operations."

C. A. L. Reed, M. D., Cincinnati: "The Conservative Tendency in Abdominal and Pelvic Surgery."

W. A. Mellick, M. D., Zanesville: "Lachrymal Obstruction."

W. J. Gillette, M. D., Toledo: "Perforating Ulcer of the Stomach."

A. B. Richardson, M. D., Columbus: "Influence of Heredity."

S. S. Thorn, M. D., Toledo: "Four Cases Representing Periods in the Evolution of the Treatment of Hip-joint Dislocation."

William Thomas Corlett, M. D., Cleveland: "Modern Status of Specific Urethritis, with its Treatment."

George W. Crile, M. D., Cleveland: "Researches Into the Technique

of Laryngeal Operations, with Report of Four Successful Total Extirpations."

John P. Sawyer, M. D., Cleveland: "Some Observations of Malarial Organisms in Close Connection with Typhoid Fever."

H. B. Gibbon, M. D., Tiffin: "Rational Medicine."

Joseph Ransohoff, M. D., Cincinnati: "Surgery of Tubercular Lesions."

James E. Pilcher, M. D., Captain in Medical Department of the United States Army, Columbus: "The Present Status of Military Medicine and Surgery and their Relation to General Practice."

M. Stamm, M. D., Fremont: "Intestinal Obstruction—Some Diagnostic Points and Treatment."

Charles N. Smith, M. D., Toledo: "Pelvic Haematocele and Haematoma."

G. F. Cook, M. D., Oxford: "Title to be announced on regular program."

S. B. Hiner, M. D., Lima: Title to be announced on regular program.

L. B. Tuckerman, M. D., Cleveland: Title to be announced on regular program.

F. F. Lawrence, M. D., Columbus: "Salpingitis."

Frank W. Thomas, M. D., Marion: "Strychnine and Nitroglycerin in the Treatment of Pneumonia."

J. W. Wright, M. D., Columbus: "The Use and Abuse of Local Medication in Eye Affections."

R. E. Skeel, M. D., Cleveland: "The Etiology and Prophylaxis of Puerfural Sepsis."

R. C. Heflebower, M. D., Cincinnati: "What the General Practitioner Should Know About the Eyes."

J. E. Brown, M. D., Columbus: "The Tropho-Neuroses of Astigmatism."

### Book-Reviews

**PRINCIPLES OF SURGERY.**—By N. Senn, M. D., Ph. D., LL. D. Professor of Practice of Surgery and Clinical Surgery in Rush Medical College, Chicago, etc., etc. Second edition thoroughly revised. Illustrated with 178 wood engravings and colored plates. The F. A. Davis Co., Publishers, Philadelphia.

In this work, the first edition of which appeared in 1890, the distinguished author has given to the profession one of the very best books on the principles of surgery now extant. The book differs from the Surgeries that have been written in former years, and even from the more modern ones, in the range of subjects discussed and the thoroughness with which they have been described. As the title of the volume indicates and as is stated in the preface, "the fundamental principles of the art and science of surgery, the causation, pathology, diagnosis, prognosis, and treatment of the injuries and affections which the surgeon is most frequently called upon to treat," are considered; hence one does not find here discussed many of the subjects which we are accustomed to see in the older works bearing the same or similar titles; "special" or "regional surgery" has been almost entirely omitted.

The book, it is needless to say, is essentially modern, and the newer researches in bacteriology and pathology, which have done so much to enrich surgery, find full recognition.

In the opening chapters, the distinction between regeneration and inflammation is clearly drawn and insisted upon, and the healing of wounds and the reparation of defects exclusively by the proliferation of fixed connective tissue cells are emphasized. The mode of regeneration in the various tissues is fully described and the resources of surgical art in aiding the process are discussed. Some of the author's own contributions to the methods of treating fracture of the neck of the femur and ununited fracture are set forth.

In regard to the ligation of arteries, he denies the necessity and advisability of tying the ligature with sufficient force to sever the intima and media, a matter to which he has in former publications directed attention.

The pathogenic bacteria, the phenomena of inflammation, the clinical forms of suppuration, pyemia, septicopyemia, and the granulomata are fully described. The author disparages the inoculation of erysipelas for therapeutic purposes. A most excellent article is the one on osteomyelitis.

One hundred and thirty-eight pages are devoted to surgical tuberculosis, twenty-one to tetanus and twenty-two to actinomycosis.

Throughout the work there is shown a thorough acquaintance with the modern literature of pathology and surgery.

Important facts are stated in italics, a feature which adds to the value of the volume. A few instances of carelessness in proof-reading are met with; the illustrations and typographic work have, on the whole, been well executed. Some fifty new illustrations have been added. C. A. H.

**THE AMERICAN LOBSTER: A STUDY OF ITS HABITS AND DEVELOPMENT.—**

By Francis Hobart Herrick, Ph. D., Professor of Biology in Adelbert College of Western Reserve University, issued by the Government Printing Office in Washington.

This work is one of the monographs issued under the aegis of the United States Fish Commission. The author may fairly be said to have lived into sympathy with his subject, as he has devoted five years to the work, spending his summers in Woods Hole, Mass., and has pursued his labors into Maine and New Brunswick. The lobster is not so hard and dry a subject as one would imagine who has only made his acquaintance in the market-house. As pictured by Dr. Herrick he is much like those mailed knights of the Middle Ages, who preyed on the soft and unsuspecting traveler as he passed by; fierce and active in its native haunts, sensitive to impressions of touch and temperature, Dr. Herrick gives one the impression that the lobster is of the sanguine-nervous temperament rather than the phlegmatic picture of misery with which we are familiar. It may be new to many that some toilers of the sea are gifted with keen powers of scent; this is the case with the lobster, which is in part a carrion-eater.

Of less interest to the public, but of great importance from both the industrial and scientific points of view, is the part of the work devoted to the mode of propagation and development of the lobster.

The style of the work is classic, the typography excellent, and the illustrations, of which there are many both in black and white and in colors, drawn from nature by the author and photographed direct, are remarkably well executed, and add greatly to the value of the book. The work is in every way a credit to its author and to his place of residence.

## Books and Pamphlets Received

**SYPHILIS IN THE MIDDLE AGES AND IN MODERN TIMES.** By Dr. F. Buret, Paris, France. Translated from French, with notes, by Dr. A. H. Ohmann-Dumesnil, M. D., Professor of Dermatology and Syphilology in the Marion Sims College of Medicine; Consulting Dermatologist to the St. Louis City Hospital, to the St. Louis Female Hospital; Physician for Cutaneous Diseases to the Alexian Brothers' Hospital; Dermatologist to Pius Hospital, to the Rebekah Hospital, to the St. Louis Polyclinic and Emergency Hospital, etc., etc. Being Volumes II and III of "Syphilis To-day and Among the Ancients," complete in three volumes. 12m., 300 pages. Extra cloth, \$1.50 net. Philadelphia: The F. A. Davis Company, Publishers, 1914 and 1916 Cherry Street.

**NEW TRUTHS IN OPHTHALMOLOGY** as developed by G. C. Savage, M. D., Professor of Ophthalmology in the Medical Department of the Vanderbilt University, ex-President Nashville Academy of Medicine, President Tennessee State Medical Society, Member English International Congress of Ophthalmology. Fifty-eight illustrations. Third edition. Published by the author. Printed at the Printing House of the M. E. Church, South. Nashville, Tenn., 1896.

**DONT'S FOR CONSUMPTIVES, or The Scientific Management of Pulmonary Tuberculosis.** How the Pulmonary Invalid may Make and Maintain a Modern Sanitarium of his Home, with Additional Chapters Descriptive of How Every Consumptive Person May Apply the Forces of Nature to Assist and Hasten Recovery. And, also, How the Defects of Heredity may be Best Overcome. By Charles Wilson Ingraham, M. D., Binghamton, N. Y. February, 1896. The Call, Binghamton.

**MEDICINE AS A PROFESSION,** one of a series of Articles on the Choice of a Profession Addressed to Undergraduate Students by Men of Various Callings Ten Years after Graduation, by Louis Faugères Bishop, A. M., M. D., New York.

**INFANTILE MORTALITY DURING CHILDBIRTH AND ITS PREVENTION,** by A. Brothers, B. S., M. S., Visiting Gynecologist to Beth Israel Hospital, New York; Attending Gynecologist to the New York Clinic for Diseases of Women; Instructor in Operative Gynecology at the New York Post-Graduate Medical School and Hospital; Fellow of the Academy of Medicine, etc. William Furness Jenks Prize Essay of the College of Physicians of Philadelphia. Philadelphia, P. Blakiston, Son & Co., 1012 Walnut Street, 1896. \$1.50.

**ELECTRICITY IN ELECTRO-THERAPEUTICS,** by Edwin J. Houston, Ph. D., and A. E. Kennelly, Sc. D., New York. The W. J. Johnson Company, 253 Broadway. 1896. Pages 402.

**THE VALUE OF BACTERIOLOGICAL EXAMINATIONS IN THE PREVENTION OF DIPHTHERIA,** by H. E. Welch, M. D., Health Officer, Youngstown, Ohio. Reprint from American Medico-Surgical Bulletin, February 29, 1896.

**DIAGNOSIS AND TREATMENT OF DISEASES OF THE RECTUM, ANUS. AND CONTAGIOUS TEXTURES.** Designed for Practitioners and Students, By S. G. Grant, M. D., Professor of Diseases of the Rectum and Anus,

University and Women's Medical Colleges; Rectal and Anal Surgeon to All-Saints German, Scarritt's Hospital for Women, and Kansas City, Fort Scott and Memphis Railroad Hospitals, to East-Side Free Dispensary, and to Children's and Orphan's Home, Kansas City, Mo.; with two chapters on "Cancer" and "Colotomy," by Herbert William Allingham, F. R. C. S. Eng., Surgeon to the Great Northern Hospital, London. One Volume, Royal Octavo, 400 pages. Illustrated with 16 full page Chromo-Lithographic Plates and 115 Wood Engravings in the text. Extra Cloth, \$3.50 net; Half Russia, Gilt Top, \$4.50 net. The F. A. Davis Company, Publishers, 1914 and 1916 Cherry Street, Philadelphia; 117 W. Forty-Second Street, New York; 9 Lakeside Building, Chicago.

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### Medical Journals and Medical Centers

In its issue of February 8th, the *Medical and Surgical Reporter* has more to say of medical journals and medical societies. We regret we have not space to quote more fully from our contemporary. It contrasts Philadelphia with New York, pointing out that the journals of the former city publish no transactions of the local societies and do not (cannot) keep the world informed as to what is doing medically in Philadelphia. "If there be such possibilities in American medical literature as journals of cosmopolitan character the New York weeklies may claim that distinction. No matter what other interests may now and again find expression in them, the New York journals always, unremittingly and consistently, promote the interests peculiar to the New York profession. The doings of the medical world, the proceedings of the international, national or state associations, the achievements of individuals, all are given ample mention as occasion may arise, but constantly and continuously are the local societies and the work of local practitioners kept in evidence. The result is that the New York profession is fully informed of what is going on in its own home and its interest is sustained and enhanced. More than that the great body of the profession outside the city is kept deeply impressed with the superior importance of the local work, and, naturally, turns to New York when seeking information or an opportunity for special study."

This indicates very clearly the lines upon which Cleveland can march to the front of western medical centers. The power of the printing press is as great in medicine as in other departments of human activity. With a vigorous journal working actively in harmony with a powerful local medical organization, Cleveland will progress rapidly in its medical career.

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**The Legislature** passed a general nuisance law increasing materially the power of local health officers. It is applicable to the smoke nuisance.

## Medical News

**A new** case of smallpox developed at Lima, April 17.

**Dr. A. H. Vance** of Springfield was in the city April 9th.

**Dr. E. R. Spencer** of Doylestown was a visitor in Cleveland April 10.

**New York** is agitated over the discovery of a fifth case of leprosy in the city.

**Dr. C. E. Schilling** of Canton was in attendance at the Cleveland Medical Society meeting of April 10.

**Dr. John B. Roberts** of Philadelphia was the guest of the Altoona, Pa., Academy of Medicine and Surgery recently.

**Dr. A. K. Fouser** of Akron has received the Republican nomination for a second term as Coroner of Summit County.

**Dr. William Thomas Corlett** of this city has just been elected a member of the Dermatological Society of Great Britain and Ireland.

**Dr. J. C. Steuer** has been removed from his position as District Physician by Mayor McKisson. **Dr. Paul Apperman** succeeds him.

**Dr. William Tripp** of Carrollton died April 11th at a very advanced age. He was a graduate of the Western Reserve School in the year 1851.

**Dr. Roswell Park** of Buffalo addressed the Medical Society of Erie County, Pa., upon "Intestinal Auto-Intoxication" on the evening of April 7th.

**Dr. O. T. Maynard** of Elyria we understand is going abroad this summer with the intention of doing some work in the medical centers of Europe.

**St. Luke's Hospital**, New York, said to be the most handsomely appointed hospital in the world, was formally opened for the reception of patients on April 16.

**The Clinical Recorder**, a quarterly published in New York, and edited by **Dr. William S. Gottheil**, is the last medical journal out. It is the organ of the new post-graduate school.

**The week** ending April 18 was the hottest ever recorded for this month in Cleveland, the temperature reaching 84° on the last day, and two heat prostrations being chronicled.

**The Dental Department** of Western Reserve University has just issued a new catalog. A unique feature is a blank certificate of moral character, the use of which by every prospective student is insisted upon.

**Dr. J. C. Sanders**, one of the oldest and most prominent homeopathic physicians in this city, and Dean of the Cleveland Medical College, has been seriously ill for some weeks at his residence, 608 Prospect street.

**Dr. Wilford W. White** of Ravenna and **Dr. A. B. Howard** of Cuyahoga Falls were in the city April 21 and took advantage of the visit of the Secretary of the State Board to signify their intention of practising medicine in Ohio.

The Baltimore medical profession is much disturbed by the appointment of two homeopathic physicians to positions in the city medical service. Hereafter all inmates of the jails when sick must submit to homeopathic treatment or none at all.

**Dr. L. C. Bean**, of the Marine Hospital Service, was tried for criminal abortion April 21 at Gallipolis. Congressman C. H. Grosvenor was attorney for the defense. The case was submitted to the jury without argument and Dr. Bean was promptly acquitted.

**Arrangements** are being made for a tour abroad by a hundred American physicians, who will visit during the coming summer the principal health resorts of Europe. It is expected that various courtesies will be shown them at the places visited.—*Science*.

The Ohio State Board of Medical Examiners, recently appointed by the Governor under the new law, consists of three regular practitioners, one homeopathist, two eclectics, and one physio-medical. What the belief and practice of the latter may be we confess we do not know.—*Medical Record*.

**Dr. Hiram Corson**, that well-known and venerable physician of Montgomery Co., Pa., died on March 4th, aged 92 years. He graduated from the University of Pennsylvania in 1828. He was a member of many medical societies and was noted for his persistent advocacy of blood-letting in pneumonia.

The New York Legislature is considering a bill creating the "Optical Society of the State of New York," and conferring upon opticians the power to prescribe glasses by power to license "refracting (*sic*) opticians." The New York profession is kept very busy this winter repelling the attacks of the Legislature.

**Senator Elroy M. Avery's** bill to enable this city to issue \$100,000 in bonds with which to establish a garbage plant, has received the recommendation of the Senate Committee to which it had been referred. The time is at hand when the plant will again be a necessity, and promptness in the passage of the bill is to be hoped for.

**Dr. Brantley Pomerene** of Mt. Hope, O., died April 11, after only four days' illness. He was a son of the late Dr. Joel Pomerene of Millersburg, who was for many years a prominent figure in the medical affairs of Cleveland, holding for some years a chair in the Wooster Medical College. He was a graduate of Wooster of the class of 1888.



**Smallpox** was an interesting topic of conversation in this city April 11. Health-Officer Hess received word from the State Board of Health that some emigrants from an infected vessel were booked to arrive in Cleveland on that date. On April 13 a carload of emigrants—41 in number—was quarantined, and one man sent to the pest-house.

**The bill** establishing a State Anatomical Board, to be composed of the teachers of anatomy and surgery in the medical schools of the State, which was endorsed by the Cleveland Medical Society and the Cincinnati Academy of Medicine, was introduced in the Legislature early in April. It unfortunately, however, met with an indefinite postponement on April 18.

**Dr. John Guiteras**, Professor of Pathology in the Medical Department of the University of Pennsylvania, is taking a leading part in aiding the Cuban struggle for liberty. A noteworthy incident is his receipt at successive times from an unknown sympathizer of checks for \$2,000, \$4,000 and \$4,000 to aid the insurgents, and \$1,000 for the widow of a Cuban journalist.

**A Committee** from the New York Chamber of Commerce has been organized to promote the efficiency of the medical library in the New York Academy of Medicine. An attempt is being made to collect \$100,000 for the library. The library of the New York Academy of Medicine is one of the most complete in the world, and is open without charge to all wishing to use it.—*Science*.

**Notice was received** by the physicians of Cuyahoga County on April 17 that a member of the State Board of Registration and Examination with the Secretary of the Board would be at the Hollenden Hotel April 20, 21, 22 and 23 to stamp and inspect diplomas and to issue certificates. The profession is grateful to the Board for this provision, as it saved the local profession a great deal of annoyance and expense.

**Dr. Thomas J. Barton**, of Zanesville, aged 49 years, dropped dead in his office April 22. He was born in Ashland and received his medical education at Bellevue Hospital Medical College, graduating in 1876. He was a member of the American Medical Association, of the Ohio State Medical Society and several other societies. He was surgeon to five railroads and a prominent man in his community.

**Prof. J. Forster** of Amsterdam, Holland, has received a call to the chair of Physiologic Chemistry at Strassburg, Germany, occupied for 25 years by the late Felix Hoppe-Seyler. Forster is known principally by his work on the production of sulfuric acid, nitrogenous compounds and conditions for the excretion of albumin through the kidneys. The Physiologic Chemical Institution at Strassburg is the finest and most famous in the world.

**Attention** is directed to the program of the State Medical Society published in this issue. It is revised to our date of going to press and contains a number of papers additional to the preliminary program which was widely distributed early in April. The program is an unusually good one and it is a pleasure to see the Cleveland profession so well represented. There should be a large attendance from this city. Make your plans accordingly.

**In our issue** of last month we took occasion to criticise some of our western exchanges for publishing an advertisement of a quack impotence and stricture cure. It is interesting to note how swift has been retribution in this instance. Besides the self-degradation and wanton insult to the subscriber there has come a nemesis in the refusal of the said quack company to pay for the advertising and in the discovery that it was purely a fraud from its organization.

**Dr. George S. Parker** of 740 Central Avenue died April 14th at St. Vincent's Charity Hospital at the age of 51. Death was due to a severe attack of pneumonia. Interment took place at Norristown, Pa. Dr. Parker was born at Sylvania, O., in 1845, and was the son of Hiram Parker, one of the first settlers of the Maumee Valley, who survives him at the age of 90 years. He was a graduate of Starling Medical College, of Columbus, in the class of 1884. He leaves a widow and a married daughter.

**The American Medical Publishers' Association** will hold its third annual meeting in Atlanta, Ga., Monday, May 4th, and considering the many recent applications for membership, a large attendance is assured. A number of new and important topics have been suggested for discussion, and the program will include papers from experienced publishers. Members and others desiring to contribute papers will be furnished valuable information upon communicating with the Secretary, Charles Wood Fassett, St. Joseph, Mo.

**The American Microscopical Society** will hold its nineteenth annual meeting in the new Carnegie Library Building, Pittsburg, Pa., Tuesday, Wednesday, Thursday and Friday, August 18, 19, 20 and 21, 1896. A hearty welcome will be extended to all interested in the microscopical sciences. Applications for membership and titles of papers to be read at the meeting should be addressed to A. Clifford Mercer, M. D., President, Syracuse, N. Y., or to Wm. C. Krauss, M. D., Secretary, 382 Virginia street, Buffalo, N. Y.

**Dr. Moses McCure Seymour**, of Painesville, died April 11th, at the age of 82 years. He was born in Litchfield, Conn., and was a cousin of Governor Tom Seymour of Connecticut, and of Horatio Seymour of New York. He studied medicine with Dr. J. G. Beckwith of Litchfield, and attended lectures at Yale. He came to Painesville in 1836. He was twice post-

master of that city, his first commission having been signed by President Lincoln. All through his life he took a prominent part in the public affairs of the community in which he resided.

**An interesting fact** apropos of the present discussion by the City Councils of a new health ordinance providing more stringently for the reporting of contagious diseases by physicians is noted in the *Medical Record* of February 22. The Supreme Court of Illinois has just decided that physicians cannot be compelled to report on contagious diseases or to render any other public service without pay. This is the more remarkable because in many States there are valid laws compelling physicians to report births and deaths. It must be a peculiarity of Illinois law.

**The Ohio State Pediatric Society** will hold its Annual Meeting at Columbus on Wednesday, the 27th of May. Those who have papers to present should at once communicate with the Secretary, Dr. Geo. M. Clouse of Columbus, giving title of paper. The other officers of the society are; President, Dr. S. W. Kelly, Cleveland, Vice-President, J. P. West, Bellaire, and Chairman of Council, Dr. J. M. Dunham, of Columbus. Any regular physician who is particularly interested in Pediatrics and a worker therein is eligible to become a member of this young and growing Society.

**The Berlin** medical societies have taken up the question of the so-called "wild Policlinic" institutes under the direction of private physicians that are cropping up all over the city, and where patients rich and poor can have medical attendance for nothing. It has been calculated that about 300,000 cases a year are treated gratuitously, and it is alleged that a large percentage of these are well-to-do people fully able to pay. Of course this represents a tremendous loss to the Berlin doctors, and it is no wonder that the medical bodies are beginning to agitate for legislation on the subject.—*Maryland Medical Journal*.

**The Iowa Medical Journal** announces that after its January number it will print no reading notices of pharmaceutical houses, believing that to be the best policy for both Journal and advertisers. Our contemporary, which is one of the cleanest exchanges we receive, is to be commended for this step. Reading notices, in our opinion, are useless to the advertisers. Because advertisers are very much enamored of them the JOURNAL has adopted the plan of printing the reading notices among its advertising pages, where they cannot possibly be mistaken for regular reading matter. We should prefer to abolish them totally.

**Santanelli**, the hypnotist, who a few months ago caused a young man in this city to remain eight days in a hypnotic trance without food, has been repeating the experiment in Ft. Wayne, Ind. He has not met with similar interest on the part of the medical profession, however, as the Fort Wayne physicians have caused his arrest on the charge of cruelty to a minor.

It will be the first case of the kind ever tried in a court. As will be remembered the Cleveland experiment resulted in a definite addition to our knowledge of the physiologic and chemical changes occurring in starvation. An exhaustive report of the case by Dr. C. F. Hoover will shortly appear. Only three cases of starvation have been studied with similar care.

**Dr. L. Duncan Bulkley** finds (*Medical Record*, January 18th), that sodium bicarbonate, given in twenty to thirty grain doses, in two or three ounces of water, every half-hour for three doses, with a fourth dose in another hour, will usually promptly abort a "cold." At the end of two to four hours, if the symptoms persist, this course may be repeated. This treatment is, of course, not so efficacious after a 'cold' is well established. This treatment is based upon the theory that an acid condition of the system irritates the terminal endings of the nerves in the skin and mucous membranes and deranges the capillary circulation. While the theory lacks facts to prove it, there is every reason to believe that this method of treating a cold will prove very useful.

**Dr. Thomas Hunt Stucky**, of Louisville, Professor of Theory and Practice and Clinical Medicine, Hospital College of Medicine, Louisville, and chief owner of the Louisville Base Ball Club, has written a paper extolling certain much advertised proprietary gold-salt preparations, which has been published in nearly all the medical journals of the West, and some of the East. It is hoped that the journals have been well paid for this service, for, however meretricious it may be for a medical journal to sell its original article space for advertising purposes, the medical profession of the West must be heartily sick of reading this same paper in almost every journal they pick up. The journals which thus deceive the profession are sure to reap their just reward at no far distant date.

The following from the *Medical and Surgical Reporter* could not be better said, and it makes good reading in Cleveland: "The best indication of the professional standing of any community is the amount and quality of the work done in its respective organizations. Reputation depends principally upon the publicity given to the work. The association which exists for the critical analysis and comparison of the work rather than the worker, which devotes its energies to the advancement of professional knowledge, and which publishes its proceedings for the benefit of the entire cult, not only accomplishes much for medical science, but incidentally most effectively promotes local interests. Work which is held constantly before the profession compels attention, the locality is identified with the work, and, naturally interest will concentrate about a place whose professional facilities are constantly in evidence. The principal equation in the problem of a medical center is thus reduced to two factors—the medical society and the medical journal. Neither may be disregarded without falsifying the situation and inevitably defeating the solution of the main problem."

**The Legislature**, to its credit, defeated the "jag-cure" bill.

**Forecasting the future** bids fair to become a very unprofitable industry in Cleveland. The new license law taxes "astrologers, fortune-tellers, seers, etc.," \$300.00 a year.

**Dr. John M. Ingersoll** will leave for Europe the latter part of May, expecting to be gone three months, which time he will spend in doing some additional work in the medical centers of the Continent.

**The closing days** of the State Legislature witnessed the passage of several laws of interest to physicians. Bond issues for the following purposes and amounts were authorized: morgue, \$40,000; garbage plant, \$100,000; water-extension and improvements, \$1,500,000; and sewers, \$750,000.

**Prof. John S. McKay** reports, in the *Scientific American* of April 18th, the production of good Röntgen pictures by placing the objects to be photographed directly upon the sensitive plate (in the dark-room) and exposing in the field of an ordinary or electro-magnet. If confirmed this experiment will be of great theoretic importance in determining the nature of the Röntgen rays.

In a **Paper** upon sea-sickness (*Medical Record*, January 25th), Dr. A. D. Rockwell reports excellent results from the use of bromids in large doses. The treatment is begun three days before sailing and consists of the administration in divided doses of 100 grains daily of a bromid, preferably the sodium salt, though the strontium salt would be of at least equal value seemingly. This certainly seems to be the best treatment for this very troublesome condition, and it is based upon an entirely rational theory, viz: that sea-sickness is due to irritation of the central nervous system by the boat's motion. The administration of bromid, therefore, is simply to diminish the irritability of the sensory nervous system. By mild bromization before sailing the sensitiveness of the nerve-cells is obtunded and the irritation prevented. Since it was first suggested by Fordyce Barker some years ago, this treatment has been constantly gaining adherents until it is today the best recognized and most rational of all the methods proposed for the relief of this troublesome condition.

**The opening paragraphs** of an editorial on "The Average Physician" in the *Medical and Surgical Reporter* for January 25th, contain some truths which could not be better expressed. The *Reporter* has been and aims to be, the journal of the average physician—a journal which shall be newsy and bright without descending to gossip and vulgarity; which shall be scientific without developing into a mass of technicalities; which shall be practical and clinical without degenerating into a symposium of ignorance. If we were asked to describe who and what the average physician is, we should begin by telling what he is not. He is not the man who writes to a journal a full account of "my own case," nor smutty reminiscences of "experiences in practice," nor who begs the advice of his "dear brethren" for a masturbator or sexual neurasthenic whose symptoms he proceeds to describe in full. There seems to be an affinity between this sort of physician and the journal with interviewed advertisements of proprietary drugs once removed from quack medicines, and whose editor answers appeals for aid in prescribing, with encomiums of *henbanis comp.*, or *Pheasant's iodidia*, or other mixtures which are extensively represented in the advertising pages.

## A Few More Opinions

A prominent Southern Ohio physician writes: "I am a regular reader of your JOURNAL and consider that in this as in many other things medical you lead the State."

Your periodical is an excellent one and should receive the hearty support of the Ohio profession.—H. EDWARD DUNLOP, M. D., Ph. G., Editor *Illinois Medical Journal*.

The CLEVELAND JOURNAL OF MEDICINE is the name of a young and sprightly addition to medical journalism. It is owned and edited by Drs. Henry S. Upson and P. Maxwell Foshay.—*Denver Medical Times*.

The new CLEVELAND JOURNAL OF MEDICINE, the official organ of that vigorous, active working body of progressive physicians, the Cleveland Medical Society, has made its appearance. It is pleasing to look upon and full of delicious reading. The student physician enjoys the spirit which called this journal into being, for with such journals, backed by such a society, the cause of scientific medicine must prosper in Cleveland. Cannot St. Louis pattern after the Athens on the inland sea, raise its standard of work accomplished and promote the welfare of medicine in this city?—*The Medical Fortnightly*.

The CLEVELAND JOURNAL OF MEDICINE is the name of a new medical journal established in Cleveland by the editors of the *Western Reserve Medical Journal*, which latter retires from the field to give place to this, its successor. The new journal is edited and published by Henry S. Upson, M. D., and P. Maxwell Foshay, M. D., the latter being business manager. It is the official organ of the Cleveland Medical Society, and the following named are associate editors on the part of the Society: Wm. H. Humiston, M. D., Chairman, 122 Euclid Avenue; Wm. F. Brokaw, M. D., Secretary of Society; W. H. Buechner, M. D.; M. Rosenwasser, M. D.; R. M. Woodward, M. D., M. H. S.; William E. Wirt, M. D., President of Society. We congratulate all concerned in the new journal and bespeak for it that success which the importance of Cleveland as a medical center and the high standing of its physicians merit.—*Buffalo Medical Journal*.

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## Condensed Table of Mortality in Cleveland for March 1896

By courtesy of Dr. J. L. Hess, Health Officer

## I—ZYMOTIC DISEASES

Measles .....	0
Scarlet Fever .....	0
Diphtheria .....	15
Croup .....	3
Whooping cough .....	2
Typhoid fever .....	19
Cholera, cholera morbus and cholera infantum .....	8
Acute diarrhea .....	0
Chronic diarrhea .....	1
Dysentery .....	0
Cerebrospinal meningitis .....	1
Erysipelas .....	0
Malarial fever .....	2
Pyemia and septicemia .....	7
Alcoholism .....	0
Inanition .....	24
	<hr/>
	82

## II—CONSTITUTIONAL DISEASES

Cancer .....	14
Rheumatism and gout .....	3
Marasmus, scrofula and <i>tubercles mesenterica</i> .....	12
Hydrocephalus and tubercular meningitis .....	1
<i>Phthisis pulmonalis</i> .....	39
Anemia .....	0
	<hr/>
	69

## III—LOCAL DISEASES

Pneumonia and congestion of the lungs .....	53
Bronchitis, acute .....	7
Bronchitis, chronic .....	4
Tonsillitis .....	2
Pleurisy .....	1

Asthma .....	2
Congestion of brain and meninges .....	9
Apoplexy .....	3
Paralysis .....	9
Epilepsy .....	0
Tetanus .....	0
Convulsions .....	55
Other diseases of brain and cord .....	2
Diseases of heart .....	27
Aneurism .....	0
Abscess .....	0
Dropsy .....	7
Diabetes .....	2
Bright's disease .....	12
Peritonitis, gastritis and perforation .....	24
Hernia and obstruction of intestines .....	2
Diseases of liver .....	4
Genitourinary diseases .....	2
Hip disease .....	1
	<hr/>
	228

## IV—DEVELOPMENTAL DISEASES

Puerperal diseases not septic .....	4
Infantile debility .....	17
Dentition .....	1
Senectus .....	30
	<hr/>
	52

## V—DEATH BY VIOLENCE

Accidental .....	12
Homicide .....	1
Suicide .....	5
	<hr/>
	18

Total deaths for March, 449. Total deaths for March, 1895, 468.

Annual death-rate per 1000 during the month (estimated population 330,279) 16.01+

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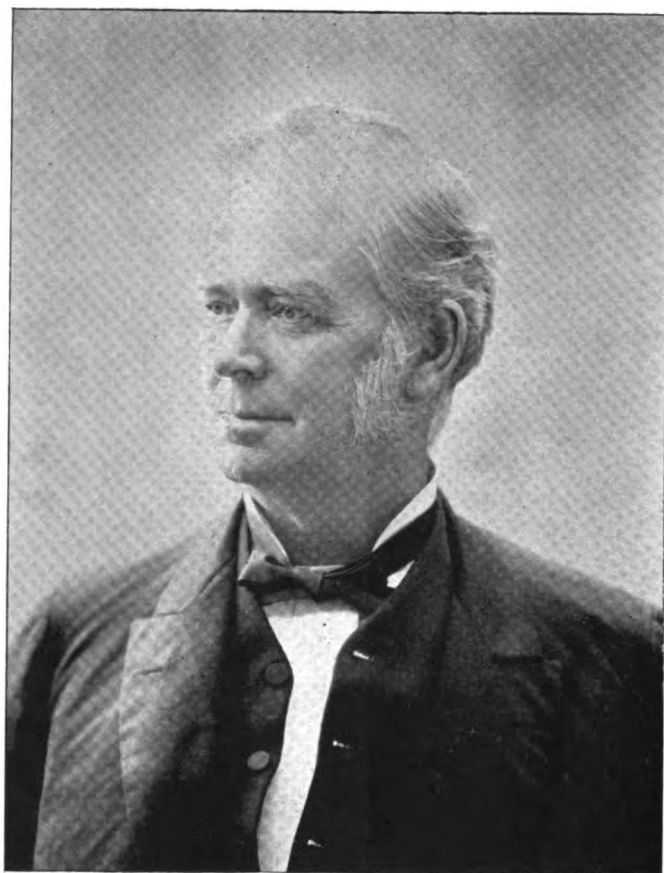
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Short notes upon clinical experiences or reports of interesting cases will be welcomed by the editors.

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· DR. W. J. SCOTT

# Cleveland Journal of Medicine

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JUNE, 1896

No. 6

## A Practical Consideration of Gonorrhea in Women

BY MARCUS ROSENWASSER, M. D., CLEVELAND

*Professor of Gynecology and Abdominal Surgery in the Cleveland College of  
Physicians and Surgeons*

IT is not my good fortune to be able to present any new revelation, or original research on the topic of the evening; nor would I tire you with surgical detail of interest only to the expert. My contribution is limited to such facts as every medical man ought to know; facts which have in recent years revolutionized our ideas, transposing the disease from the list of slight, benign ailments to the list of those of serious, dangerous, tragic import. Not less than 12 per cent. of all the women who consult the specialist, exclusive of prostitutes, have gonorrhea or its sequelae. It is the cause of not less than 15 per cent. of all cases of puerperal fever. It is responsible for 70 per cent. of all cases of sterility in woman. It is the skeleton in many a family closet. Permit me to give it the first airing before this society. The following is a typical case:

Case.—In February, 1888, I was called to see a recently married woman who was then seven months pregnant. She had been suffering with pain and swelling in knee and ankle joints, and also with frequent labor-like pains. No relief from salicylates. In April she was delivered by forceps applied low in the pelvis without injury to the soft parts. In less than 24 hours after confinement she was motionless with pelvic peritonitis, from which she recovered after months of invalidism, several abscesses having discharged through the vagina during her illness. She has not been pregnant since, and has had one recurrence of peritonitis. The baby had a mild ophthalmia.

*Read before the Cleveland Medical Society, April 24th, 1896*

This was just after the awakening of the profession to the idea of cleanliness and asepsis in surgical and obstetric work. The case had been managed in the up-to-date fashion. I was therefore not a little puzzled to know whence this streak of bad luck. During her convalescence she gave these additional links in her history: Her health previous to marriage had been good. Never had had rheumatism. Had nothing but sickness since the first week after her wedding. Three months after this event her husband's doctor had lanced a painful abscess about the vulva. The latter fact was confirmed by the doctor himself, as also the fact that he had treated the husband for gonorrhea about a year before marriage.

Cases with such sequence of symptoms emanating from a common source were recognized clinically long before bacteriology came to our aid to attach the seal of science to our conclusions. Noeggerath was supposed to have exaggerated clinical observations until Neisser, Bumm, Sanger and Wertheim verified and vindicated nearly every assertion made in the modest little pamphlet of twenty-four years ago. 'What are the facts as now accepted?

The statement that "a certain case of gonorrhea might have originated from making water in the night air" is no longer tenable. The gonococcus of Neisser, in whatever diseased tissue present, is positive evidence of its gonorrheal origin. While the germ vegetates best within epithelial tissues provided they are delicate, soft and moist, it also proliferates within and on the peritoneum and induces inflammation in connective tissue. Dry horny layers of epithelium form an impenetrable barrier. It therefore flourishes in the vagina of young children, and aged and pregnant women, but is rare in the same tissue of healthy adults. It thrives in the conjunctiva and mouth of the new-born and in the rectum of both sexes. Its presence in the urethra, the ducts of the glands of Bartholin, the vagina, the cervical canal, the uterine cavity, the tubes and on the surface of the ovaries causes inflammation of these organs. Its penetration into the lymph spaces produces broad-ligament infiltration, often leading to abscess. It can, by the same route, reach the hilum of the ovary and cause ovarian abscess without having passed through the tube. It can enter the circulation direct and reach remote organs, thus causing gonorrheal metastasis. The locations of choice are the urethra and the vaginal portion of the cervix. A person may in time become accustomed to his own brood of germs, so that they may cease giving trouble. Let them be transplanted to new soil, they at once affect the recipient with pristine vigor. Now if these regenerated germs be returned to their original owner they will initiate as vicious a recurrence as though they had never been there before. This is the explanation of "latent" and "recurrent" gonorrhea. Thus, too, a man and wife may finally become indifferent to their own germs, but a third party may be infected by either. This third party may in turn reinfect husband or wife, and these again one

another. Chronic gonorrhea therefore affords no immunity against an acute attack. Infection may be propagated by other means than sexual congress in its natural or perverted forms. Towels, sheets, sponges, baths taken in common, infected instruments, contact with secretions at birth—all are known to have been carriers of infection.

In most instances of gonorrhea in women we are called at a time when the disease has already developed a pelvic inflammation. The initial evidences about the vulva may have disappeared. When seen early a little pus can be squeezed out of the urethra, and there is a redness about the mouths of the vulvo-vaginal glands. Urethritis does not seem to be nearly as painful as in the male, unless complicated by cystitis; nor is it as tedious. The red spots in the fossa navicularis may persist and furnish a clue to the identity of the disease when other symptoms have entirely vanished. I have not found these red spots as often as one might expect from the study of Japp Sinclair's excellent monograph on this subject. Abscess of the Bartholinian glands is nearly always of gonorrheal origin. The following apparent exception proves the rule: Several years ago my friend, Dr. Allen, confided to me a rare instance of what he believed to be non-specific Bartholinian abscess in a young lady of highly respectable family. No names were mentioned. I happened to know a young lady under the doctor's care corresponding to his description; I also knew a young gentleman who had been very attentive to her. It was a strange coincidence that the young man was at the same time nursing a very stubborn dose of urethritis. Thus are we occasionally the dupes of circumstance. Gonorrheal vaginitis is rare except in young girls, the aged, and when contracted during pregnancy. The vaginal mucosa, possessing tough epithelium convertible into epidermis, resists the invasion, except when constantly bathed by the discharge dripping from the cervix above. In acute vaginitis the mucus membrane is highly injected, swollen and tender. There is a copious yellow or greenish-yellow discharge, sometimes tinged with blood. Examination causes considerable pain. In women of unclean habits the discharge causes irritation and swelling of the vulva and may infect the rectum. Not a few cases of anal fistula and rectal stricture in both sexes have their origin in gonorrheal infection. When inflamed, the vulva is constantly smeared with a copious sticky muco-pus of characteristic odor. A similar layer of ropy muco-pus on the cervix is a reliable clinical sign of gonorrhea, even when other landmarks are missing. The germ may long lurk in the crypts and folds of the cervical canal without ascending into the cavity of the uterus, causing a muco-serous discharge only. The introduction of a sound, or the use of cutting instruments about the parts, or any disturbance of the quiescent state may rapidly light up a peritonitis. Many a supposed puerperal sepsis may originate in this manner. The presence of the gonococcus in any of these secretions, as demonstrated by microscope and culture test, is proof positive as to the gonorrheal

origin of the inflammatory and suppurative diseases in the pelvic cavity. Specific puerperal fever is usually distinguished from that of septic origin by later appearance, more tedious course, greater liability to recurrence and safer termination as to life.

Tubal infection is frequently followed by sterility. When not entirely closed, the tubes may be more or less crippled and may become the seat of ectopic pregnancy. Uterine gonorrhea is characterized by menorrhagia, dysmenorrhea, leucorrhea. It often causes repeated abortions, occasionally premature labor. While infection of bladder, kidneys and rectum is common to both sexes, the frightful consequences and untold misery of pelvic peritonitis and suppuration, and of puerperal sepsis have no parallel. Indirectly ophthalmia neonatorum and the specific vaginal infection of little girls seen especially among the filthy, can be permitted to follow in the wake of this procession of afflictions.

Like other infectious diseases, gonorrhea is self-limited, healing spontaneously in four to six weeks. In the chronic form the urethra is often found well without having undergone treatment. Reinfection by diseased husband, or other disturbing elements lead to extension of the disease and to its chronicity. The resulting damage to infected tissues is more or less permanent. In the treatment of acute gonorrhea, rest in bed, prevention of sexual relations, cleanliness of the vulva and other exposed parts, liberal filling of the vagina with powdered boric acid, bland diet and drink, open bowels and opiates for relief of pain would suggest themselves as sufficient. The abortive treatment by strong antiseptics or astringents, or by other violent measures is to be emphatically condemned as a refinement of aimless cruelty. The very barriers that nature provides to stay the advance of the disease are by such means destroyed without corresponding assurance of its simultaneous annihilation. Even mild douches may do more harm than good by washing germs from the vaginal entrance to the cervix where they find favorable pastures and hiding-places.

The large majority of cases that come to us are past the acute stage. Here local treatment is desirable. Prohibition of sexual relations is essential to early cure. Urethritis can be treated as in the male. Vulvitis, vaginitis and cervicitis yield most satisfactorily to dry wiping and thorough dusting with boric acid about three times a week. The cervical canal is best left undisturbed for a time, unless there is evidence that the infection has gone beyond. The proposition to completely extirpate the inflamed Bartholinian gland is regarded with favor, because it being difficult to eradicate the germ in this situation, the secretion might lead to reinfection of the male, or of the patient herself. All cases of uncomplicated chronic endometritis are best treated by curettement. We no doubt curet many such for sub-involution or septic condition, not knowing that they are gonorrheal. Many women are thus cured and would remain cured but for reinfection by the diseased husband.

In pregnant women infected at term the additional precaution of thorough scrubbing of the vagina with soap and creolin or carbolic acid at the onset of labor is necessary, just as is done in preparation for any vaginal operation. Clinically this necessity is recognized whenever there is a yellow discharge, especially if acrid enough to irritate the vulva. Once the tube has become infected the efficiency of local treatment becomes very uncertain. Curetting, by improving drainage, may occasionally cure. Early closure of the abdominal ostium is nature's first provision in minimizing the resulting danger and damage. I present a sample of her best efforts:

Case.—Ten years ago the mother of three children was infected by her husband. Her previous health had been good. The disease reached the peritoneum in ten days. The tubes could be felt as tender cords in the sides of the pelvis. The peritonitis was not severe. Six weeks after recovery from the acute symptoms a pear-shaped, fluctuating tumor developed and disappeared, first on one side then on the other—double hydrosalpinx. The fluid never emptied through the cervix; it must have gravitated into the pouch of Douglas. The germs, if any were present in this fluid, were too weak to set up a peritonitis, as the patient would recover from the rupture in a few hours. She has remained sterile. She has been so well the past five years, enjoying social pleasures and amusements, that I have had no opportunity for further examination. For details of this case refer to "Boston Medical and Surgical Journal," January 24, 1889, page 86.

Time was when the diagnosis of specific salpingitis, or of pyosalpinx implied the verdict, laparotomy. We have so far recovered from this dictum of earlier days, that each case is now judged without reference to class and is treated according to its individual indication.

Our efforts and measures for limitation and protection ought to be increased and improved in accordance with the well-known character of the disease. The sanitary supervision of prostitution has hitherto failed because of crude and incomplete methods. This matter is still controversial and involves questions of morality, ethics and hygiene which we can only mention, but have neither time nor inclination to discuss. Those who are infected, men as well as women, ought to undergo proper treatment with prolonged subsequent observation before sexual relations are resumed. Marriage ought to be prohibited in case a complete cure cannot be effected. The physician should be scrupulously careful lest he convey germs by unclean instruments or hands. He should exercise the necessary precaution at childbirth to protect the babe against maternal infection. His instructions should be explicit and rigid to protect the children against all forms of contact in event of gonorrhea of either parent.

The Herculean task of prevention rests largely on our shoulders as medical advisers. In family life gonorrhea is usually introduced by the diseased husband, either on the nuptial night, or after sexual abstinence

caused by absence, sickness, or parturition. The bride, wife, or mother comes to us in her innocence and ignorance often too late to avert the havoc wrought. We are even obliged to keep from her the real cause of her trouble. The male is the party to look to for redress. When he is infected, it does not take long for him to find it out, nor do we keep him in ignorance when, sooner or later, he is obliged to present himself for treatment. Whether he be a young man, or erring husband, the culprit is for the time our prisoner. Here is our opportunity to impress upon him the evil consequences of infection. There is no appeal as strong or as effective as that for the protection of a mother, wife, or sister against disease, lifelong misery, or death itself. My friend, Dr. R. B. Hall, has so forcibly expressed similar views that I close with a free quotation. "The family physician should impart knowledge upon every legitimate occasion upon the subject of gonorrheal infection. He should instruct the parents of boys, and the young men themselves, of the great danger to the health of their future wives should they contract gonorrhea. When we appreciate the fact of the great delicacy and hesitancy on the part of parents in talking about these subjects to their sons, we begin to realize what an enormous subject we have before us. But it is a just and righteous one, and one that is bound to be thoroughly aired by the laity in the near future. The sooner the medical profession does its plain and whole duty in the matter, the better for us all. It is within the recollection of the majority of my hearers when we, as college students, were taught that gonorrhea amounted to but little more than a cold, and could be cured in nine days by a little balsam of copaiba and a mild astringent wash. We need not wonder at the position the laity take on the subject. These older teachings must be revised and the laity must receive instructions through the family physician. We should teach that gonorrhea is more destructive to woman than syphilis.

"While on this subject we must not forget the duty parents owe their daughters as well. As sure as time, when the laity become educated upon this point, the parents and guardians of young girls will be as careful to inquire after the moral and social character of their daughters' suitors as they are now wont to do about the size of their pocketbooks. The former I think the more important, both as to comfort and happiness of the girls.

"When the laity become educated upon this subject as the profession now understand it, the abdominal surgeon will make fewer sections for these preventable diseases than he is now doing, and a corresponding amount of misery and death will have been prevented."

## Uterine Fibroids Complicated by Pregnancy

BY DUDLEY P. ALLEN, M. D.

*Professor of Surgery in the Medical Department, Western Reserve University,  
Visiting Surgeon to Lakeside Hospital and Charity Hospital,  
Member of the American Surgical Association*

RECENTLY there have come under my care two cases of fibroid tumors of the uterus associated with pregnancy. The growth of the tumors in both cases was so exaggerated as to make a record of the cases interesting. One of these was seen in consultation. Upon the other I performed hysterectomy. The cases resemble each other so closely that they may in a degree be described together. Both patients were between 30 and 35 years of age. They had had previous good health. They had had no trouble referable to the reproductive organs, and they were pregnant for the first time.

The case which I saw in consultation had at the time of my examination advanced to between the third and fourth month of pregnancy. The patient had complained of great distension and great abdominal pain. She had not menstruated for three months. I was asked to see the patient, and examined her first under complete anesthesia. At this time an irregular mass could be felt in the abdomen, filling its entire lower portion, and reaching halfway between the umbilicus and the ensiform cartilage. Before pregnancy the patient had noticed that she could feel a small mass in the lower portion of the abdomen. This had grown with enormous rapidity until at the period mentioned the mass had reached a volume equalling that of pregnancy approaching, if not at, full term.

The question of the best method of caring for the case received careful consideration, and after consultation it was decided to pursue a conservative plan. Everything was done for the patient's welfare, and her condition remained satisfactory until between the sixth and seventh month. At this time there was a discharge of fluid which indicated to the attending physician that the fetus was dead. Conditions, however, over which he had no control prevented any interference, and it was not until about two weeks later that the fetus was removed, being found lying in the vagina. Every precaution was taken against infection, but some days later a chill occurred, and although every effort was made by curetting and flushing to cleanse the uterus infection resulted, and the patient at length succumbed to secondary infection after an illness of about seven weeks. What the course of the case would have been had an operation been performed either to induce abortion or for the extirpation of the uterus at an early date, it is impossible to say. It is also impossible to say what the result might have been had it been possible for the physician in charge to have removed the fetus and introduced anti-



septic measures immediately upon its becoming evident by the discharge of fluid that the fetus was dead.

The second case coming under my professional care not long after, with a very similar history, decided me to try another method of treatment. A portion of the patient's history has already been given. As has been stated, the patient had had excellent health, had been unaware of any difficulty with her reproductive organs, and had menstruated six weeks before I saw her. On examining the abdomen, however, a large, irregular mass could be felt, filling the whole abdominal cavity, and reaching above the umbilicus. By bimanual examination it was easily determined that this was a multilocular fibroid tumor, complicating pregnancy. An immediate operation was advised and undertaken and the tumor with the uterus was removed, the line of amputation being just above the cervix. The amputation was made by a wedge-shaped incision, sufficient peritoneum being saved thoroughly to cover in the stump. There was small loss of blood, and the operation was performed very satisfactorily in every way. The difficulties of the operation were very great, since one portion of the fibroid had developed in and become so firmly wedged in the pelvis that it was only removed with extreme difficulty, and the employment of great force. During the operation the patient's heart was very weak, and her condition at times was critical. The anesthetic was administered by Dr. Lee, who told me at the close of the operation that at one time he feared the patient would die while the operation was in progress. The pulse at the close of the operation was 130. The cavity of the pelvis was packed with a Mikulicz tampon, and the lower part of the wound was left open for drainage. The patient reacted well, and on the evening of the day following the operation she had a temperature of 99.4, and a pulse of 106. On the following day, however, it became evident from the belching of gas and the distension of the abdomen that there was some obstruction of the intestines. Forty-eight hours after the operation the Mikulicz tampon was taken away in the hope that by its removal any obstruction to the action of the bowel might be overcome. It gave, however, no relief. Seventy-two hours after the operation there escaped from the bowel a large amount of flatus and some fecal material, following the administration of an enema. The same recurred two and one-half hours later. Though temporarily relieved the patient gradually sank with increasing distension and pulse-rate, until she died four days and ten hours after the operation. At the examination after death it was found that a knuckle of gut was adherent to the stump, and being bent in an acute angle had rendered impossible the passage of flatus. The point of obstruction was found twelve inches above the ileo-cecal valve.

There had been no inflammation, and no evidence whatever of any septic condition, and the death was clearly ascribable to one of the accidents

of operation. In an experience with laparotomies, which may fairly be said to be considerable, this is the second case which I have met of obstruction of the bowel due to its attachment to the stump. In the other case the patient lived fourteen days.

My reason for reporting these two cases is primarily because of their rarity. As is well known in many cases of fibroid of the uterus pregnancy never occurs. I have seen a large number of cases of this sort. In many other cases which I have seen there is a history of a single pregnancy, occurring immediately after marriage, and there has been no knowledge of anything abnormal either during or after the pregnancy. Later on a growth has been discovered in the abdomen. On examination it has proved to be a fibroid tumor. I have seen many cases of this sort which, as has been said, have had a history of a single pregnancy, and the case has come to me for examination at a period of from fifteen to twenty-five years subsequent to the pregnancy. I have also seen a considerable number of fibroid tumors in which there has been a history of repeated abortions. These usually occur early in pregnancy. The two cases just described are, however, the only ones in which I have met an enormously rapid growth of the tumor thus associated with pregnancy. I am inclined to the belief from my personal experience that this rapid growth of a fibroid tumor in connection with pregnancy is a relatively rare occurrence. In both these cases the growth was of greater rapidity and volume than I have ever seen under any other circumstances.

The cause of such growths is of course a matter of great interest, and the explanation which naturally suggests itself is that the increased blood-supply which is found in connection with pregnancy in some way facilitated the growth of these tumors. Why it should occur in one case and not in another is difficult to explain. A further question of interest in connection with these cases is as to the best method of treatment. Of course two cases offer no solution whatever, especially as in both of these cases there was an unfortunate complication resulting in death. In the case which was treated without operation the physician was unable to secure the delivery of the fetus promptly upon the evidence of its death, and was also unable to institute at once antiseptic precautions. Had he been able to handle the case according to his preconceived plan it is possible that the patient's life might have been saved. In the second case the dangers seemed to be safely overcome, and a fortunate result was only prevented by the adhesion of the bowel to the stump, a complication which has occurred but once before in my experience in laparotomy.

## Some Common Affections of the Heart and their Treatment

BY H. W. ROGERS, M. D.

*Professor of Medical Diagnosis and Clinical Medicine in the Cleveland College of Physicians and Surgeons*

**I**N this age of progressive medicine, when so much is being accomplished in the lines of bacteriology and pathology, looking towards more exact methods of diagnosis and treatment, one may perhaps apologize for inviting your attention to a class of diseases so common as affections of the heart.

For centuries keen and close observers have written upon the subject, and yet today how often are the changes in the heart's mechanism or structure overlooked until some sudden death reminds us that slight irregularities or obscure general symptoms are undiscovered or perhaps misinterpreted. Fibrous arteries, accompanied by hypertrophy and dilatation of the heart are far too common in advanced life to require more than a passing notice, but where and when do these changes begin? And how may we avoid or at least delay their development? Does every case present the same class of initial symptoms and are all cases amenable to the same plan of treatment? We believe that this may be answered most decidedly in the negative.

It is a well-known fact that the majority of men at, or near middle life break down in health and are unable to perform their accustomed duties, not all making the same complaint nor presenting the same variety of symptoms. This does not always occur at a particular age, for we are not all endowed with the same vitality nor are the demands upon the life-giving forces the same in every individual, but sooner or later, and to a greater or less degree, changes do occur, which force upon us the recognition of that well-established law that an intricate machine cannot run forever without rest and repair. It is at this period that the foundation is laid for the conditions so readily recognized later on.

Balfour, in that most excellent monograph on the Senile Heart, has said that "It may be accepted as an axiom that all cardiac symptoms complained of after middle life that cannot be distinctly referred to some evident disease or to some affection of the cardiac mechanism due to disease, may be regarded as originating in some actual or relative weakness of the myocardium, and the symptoms may be of the most varied character." While this in the main is probably true, it is likewise true that the heart in and of itself may show but little evidence of its disturbed function. The most commonly met subjective symptoms referred directly to the cardiac region are first a sense of oppression or dull pain sometimes accompanied by violent throbbing, dyspnea, precordial distress, periodical or constant, more often the former.

*Read before the Cleveland Medical Society, May 8, 1896*

In regard to those cases which are considered purely functional it may be a strong question whether many of them do not initiate the more serious lesions found in later life. True the heart has a large amount of reserve force and is able to overcome many obstructions and disturbances, but with the possibility of irreparable damage being done which is slow in revealing itself. Percussion often reveals but little; for the cardiac area of dullness is seldom increased except it be late in the course of the disease. Palpation usually shows the apex-beat quite in its normal position, sometimes strong, at other times weak, and this weakness may in many instances be ascribed to conditions of the chest wall.

It is then to auscultation that we turn for any evidence of cardiac derangement. We find as a rule no murmurs, the sounds clear and fairly well-defined, but almost invariably a marked accentuation of the second sound at the aortic orifice, which means loss of elasticity in the aorta and in some instances dilatation of its lumen; added to this in a certain proportion of cases, the first sound at the apex has lost that booming character which is characteristic of a contraction of the left ventricle when in normal tone.

There are two prime causes for this condition of sound. First, those cases in which the sound is strong are usually accompanied by obstruction in the peripheral circulation, evidenced by high tension in the radial arteries, but the nutrition of the heart-muscle has remained good, leading even to a slight hypertrophy; secondly, when the first sound is weak the radials are not always found diseased, but the heart-muscle lacks nutrition, sometimes from diseased coronaries and at other times from deleterious or inefficient blood-supply.

With reference to the pulse, its condition varies. Bradycardia and tachycardia are the most common forms of irregularity which it has been my experience to meet in this class of cases. It is my belief, however, that there are few conditions of the pulse pathognomonic of a particular cardiac lesion. The nervous mechanism of the heart plays an important role in the modifications of pulse-rate, force and rhythm, often observed in those disturbances we call functional and those which arise from the use of drugs such as coffee, tea and tobacco. We are constrained to believe, however, that a rapid pulse in most instances means a weak myocardium. A slow pulse on the contrary means a heart which is over-burdened by some form of resistance in the accomplishment of its labor, but a myocardium which is in most instances essentially strong.

Pain arising near or in the cardiac area and streaking upward and outward to the upper extremities, especially the left, is probably one of the most common and most distressing symptoms met with. In fact it is in many cases the first local manifestation of disturbed heart-action. From the slight

pain which shows itself in some there is every gradation to the most intense angina returning at irregular periods on the slightest exertion, many times without the least apparent cause.

Cardiac dyspnea is no less an angina than is the sharp lancinating pain which it has been our custom to regard as the only true evidence of it. From the early manifestations of cardiac change incident to age there is of course every gradation to the most intense forms of organic lesion.

It will be observed that the most common symptoms met with, particularly those which are determined by auscultation, are the departure from the normal tone of sound in the heart-muscle and aortic valve, the former meaning either hypertrophy or weakness with, perhaps, dilatation—the latter a diseased and inelastic aorta. Granting this to be true it is the object of this paper to show that there are causes for this condition of the myocardium and aorta in by no means a small proportion of cases other than those commonly accepted. Balfour says that disease, not age, terminates life even at the most advanced periods. But he argues that “Life is a gradual process of development, with initial and terminal phenomena, and that by early recognition of the commencement of the latter we may in many instances check their progress.” Also please note what this writer says: “Life is an energy, we take it in as food, and transform it with the oxygen circulating in our blood, but these remain plentiful and the immediate cause of decay must be sought within the body.

“So too impoverishment of the blood which has been regarded as the cause of the gradual failure in the aged, is itself due to imperfect assimilation and leads to imperfect oxidation and the consequent failure in the genesis of force, and that imperfect assimilation is one of the most important links in the chain of causes which lead to the general decay of the body, and the difficulty is to say where this chain begins.”

He further says: “The more we investigate the phenomena of decay, the more clearly do we see that this does not arise from any failure of the sources of potential energy, but solely from the inability of the organism to make use of those presented to it, because it has itself become effete as the direct and necessary result of development.”

Let us assume then, as this most excellent writer argues, that from the moment of birth there is a process of gradual development up to the period of full manhood, but that there is an increase in the blood-pressure brought about by the growth of the arterial and capillary system not keeping pace with the growth of the heart.

Balfour now quotes from other authority, that “Changes take place in the arterial system, which change is loss of elasticity, by which they are converted into rigid tubes with dilatation of their lumen, and consequent lowering of blood-pressure. With this lowering of blood-pressure effacement of some of the capillary areas takes place, to which latter is due the dry

and wrinkled skin, the gray hair and the cessation of functions pertaining to sexual life."

In opposition to this Balfour argues and quotes from Foster that "While the result is essentially the same it is brought about in another way; while in youth the relative large caliber of the arteries, combined with its low blood-pressure is practically the same, yet it is ample to keep up a continuous flow in the capillaries. In age, however, the loss of arterial elasticity throws greater strain upon the heart itself and makes the circulation in the capillaries approximately intermittent."

Further he says, "The cessation of active growth makes the large network of capillaries unnecessary and the lowering of blood-pressure within these vessels permits many of them to obsolesce."

We believe that this latter point in the argument is incorrect and that it requires as large and healthy a net-work of capillaries to carry on the process of nutrition in the fully developed body with all its intense and varied sources of waste as it does to produce the growth in one not yet fully developed. We can agree, however, that it is along these lines that the process takes place which ultimately leads to cardiac disease in the aged.

It is my desire to invite your attention to what seems a great error; these authorities maintain that the blood-pressure is raised by loss of elasticity in the arterial coats and this loss of elasticity changes a steady flow of blood in the capillaries to one that is practically intermittent, but they admit that the arteries are not by any means uniformly found diseased even at the most advanced age.

The three great factors in modifying blood-pressure are the force of the heart-beat, the amount of blood and the resistance offered to its passage through the arterial system.

Let us now turn to some of the causes which help to determine the changes which have been enumerated. Acute and chronic disease, especially dyspepsia, over-indulgence in food, violent and prolonged exertion, inhibition of the heart's action by emotion (this order of causes has been taken from Balfour's work on the "Senile Heart") are all the common environments of the life of every person, and they unquestionably play an important role in the development of cardiac disease but in a more general way than is by this writer anticipated. The senile heart then is one with a myocardium changed largely by overstrain, sometimes weak, sometimes strong. If the former condition exists the heart is large with dilated cavities, if the latter, there is a preponderance of hypertrophy, the last named being essentially the gouty heart of the English writers.

Arteriosclerosis is caused by lack of vitality of the individual, the chronic intoxications, the toxins of acute specific disease, excessive labor, and indulgence in the luxuries of life to more than a moderate degree; laying aside

for a moment the question of vitality and labor, the others may be placed under one heading, irritants.

The structure of the blood-vessels is not the same throughout the whole vascular area; the aorta differs from the rest of the arterial system by its large amount of connective tissue, the capillaries by being composed largely of epithelium. Granting then, that capillary obsolescence is the primary cause, so far as the vessels are concerned, and that aortic inelasticity is the common lesion, we would now ask this question: Which is the most common pathologic condition, that resulting from connective tissue and epithelium irritation or that of irritated muscle? Certainly the former. Now what are the sources of the irritant? Those just enumerated, the emotions of life, are not half so liable to inhibit the heart, for that organ goes on day by day regularly for a time at least, amid all the perplexities. They are much more likely to produce a jaded and worn nervous system. The result is imperfect digestion, formation of products of decomposition, which, entering the blood, become at once potent factors in irritating the whole vascular apparatus; and what more probable than that those points most susceptible will most likely become diseased? Why is this more constant in the aorta and the capillaries? First, their structure predisposes; and secondly, the mean blood-pressure is greater in the aorta than elsewhere, and the circulation in the capillaries is very slow comparatively, allowing a prolonged contact of the irritant. Many of the cases presenting this condition never complain of dyspeptic symptoms at all, but if you inquire carefully into their history and condition, the elements are there; namely, constipation, flatulency, sour eructation, at times one, at others all, but in such moderate degree as to be unnoticed until the attention of the patient is called to them.

The close connection between the heart and the sympathetic nervous system is through the accelerator nerve, the action of which is to increase rather than to inhibit the heart's action, and to augment its force; inhibition does take place in some instances first, but it is slight compared with the increased rate and force which follow. There is a certain, perhaps small, proportion of cases with angina pectoris as a prominent and distressing symptom which, upon autopsy, show no involvement of the coronary arteries, and also cases which never show the angina which is evidenced by the excruciating pain, but only that form giving rise to dyspnea, and some which show both forms in which there is present extensive coronary disease. There are many cases of atheroma of the coronary arteries in which there is never the slightest subjective symptom of cardiac disease until with the first attack of disturbance of function, death is sudden and without warning. Without entering into the discussion of the pathology of angina pectoris it is sufficient to know that it is the cry of distress from an over-burdened and poorly nourished heart, and the vasomotor angina pointed out by "Nothnagel" is not unlike those cases in which it arises where no coronary disease exists.

## SUMMARY

The prime lesion then, at the beginning, is a weak heart-muscle which has been produced from peripheral resistance due to capillary effacement with its consequent raised blood-pressure, invariably accompanied by aortic disease, sometimes by general arterial structural change. If nutrition be fairly good the muscle will meet the emergency by hypertrophy; if not, by dilatation. It might also here be added that the blood may hold a good amount of the elements of nutrition and at the same time those which are sources of irritation to the vascular apparatus.

## TREATMENT

The treatment of these cases at their initiation resolves itself into two factors, hygienic, including diet, and medicinal; and far too often the former is lost sight of in the management of them.

We are all conversant with those conditions of the cardiac muscle in which a weak pulse and weak sounds are very strongly suggestive of myocarditis, fatty degeneration, or some organic change, when perhaps the main lesion is a myocardium that is only weak through strain and poor nourishment. Here blood-analysis will often show anemia to be present and indicate at once treatment by rest sufficient to quiet the organ combined with baths and systematic exercise; for the cardiac muscle is as susceptible of tonic treatment with well-regulated exercise as any other muscle of the body. Apply this in conjunction with a diet calculated to restore the elements of nutrition to the blood and tissues and very little need be done with medicine, more than to correct the disturbed function for the time being. It has been so common to find an excessively acid condition of the urine, even to the deposition of large amounts of uric-acid crystals, and manifestations of gout, that we certainly can not overlook the employment of the alkaline salts as therapeutic agents. It has long been thought that potassium iodid was valuable in removing, or least delaying, the further progress of arterial degeneration; this combined with alkaline or other baths by which the excretion from the skin is increased certainly modifies and often causes, for a time at least, the disappearance of the symptoms of cardiac derangement.

A diet restricted to those articles which are most easily digested and assimilated forms an important part of the treatment. Limitation of starchy foods and sweets and the employment of rapidly appropriated proteids is the general plan. A very important point is to consider whether dry food, with a small amount of liquids, shall constitute the bulk of the nourishment. This can best be decided by the volume of blood present as evidenced by the signs of plethora or the converse. Before we pass to the discussion of medicinal agents allow me to present briefly two illustrative cases.



Case I.—Mr. R——, 55 years of age, a merchant, gave the following history: For about six months he has felt a sense of oppression in the cardiac region, never severe pain; dyspnea has been more frequent at night, with insomnia and constipated bowels. He has been treated for various forms of disease with very little benefit. He informs me without the least questioning on my part that he notices if he has been especially disturbed in business affairs, and then has his food, there is very soon developed a sense of oppression with one of impending danger. Physical examination reveals the apex slightly displaced to the left, and very little, if any, increase of cardiac dullness. On auscultation there is marked accentuation of the aortic sound. A slight murmur is present, systolic in time, heard only at the apex. The pulse is forty, full, and of high tension. The urine is acid with a deposit of a large quantity of uric-acid crystals. Treatment, absolute rest from business for two months, regulated diet with small quantity of liquids; tea and coffee forbidden, as well as all forms of stimulants was given in small doses. Iodid of potassium was given in small doses and nitroglycerin was tried but produced discomfort. Small doses of strychnin were given intermittently. Bromid of sodium and chloral for a short time to produce sleep. From the beginning the patient has improved and is now able to attend to his business every day with no distress or inconvenience.

Case II.—Mr. M——, aged 50, traveling agent, while on the road was taken suddenly with sharp pain beneath the sternum at about its middle portion extending to both arms. The excruciating pain ceased in a few moments followed by a dull constant one allowing him, however, to reach home. When first seen by me two days after the commencement of the attack the dull pain still continued. Examination of the urine revealed excessive acidity. There was accentuated aortic sound, but no murmurs were present. The cardiac area of dullness was not increased. The apex was in normal position but the impulse was weak. Pulse 100, high tension, with slight irregularity of force and rate. Treatment: Rest in bed for five days, diet restricted, and nitroglycerin with small doses of opium, 1-6 grain every three hours. All unpleasant symptoms soon disappeared, and much against my advice the gentleman resumed his business but informed me afterwards that he carried, and occasionally took, the medicine. It is interesting to note that I attended this same person eight months thereafter for a typical attack of acute gout, but found his heart working fairly well. It is my expectation that I shall sometime see him again.

Digitalis is the ideal heart tonic. Its action is through the pneumogastric to the base of the heart, principally the auricle, but there is one action of digitalis often lost sight of, by some writers at least; the heart has its own independent ganglia distributed in the ventricular walls, and the drug plays its most important role by a direct tonic effect on this portion of the cardiac mechanism.

Strophanthus is quite similar in its action but is generally held to be unreliable, though quite likely to be of benefit in those cases where digitalis fails. It would be my suggestion that the difference is largely that between a stimulant and tonic. Strophanthus is a cardiac stimulant. Strychnin is one of our most potent remedies, but its action is powerful and rapid, and there is, I believe, great danger that if used too frequently or for too long a period we over-stimulate and thereby defeat our purpose. There is a strong tendency to use strychnin to a degree that is unwarrantable and even dangerous. A tired or diseased heart-muscle can not respond to stimulation with readiness, nor is it in a condition to tolerate it without rebelling against the lash which this drug certainly represents.

If peripheral resistance is the primary cause of the heart's irregularity and distress, those drugs which lower blood-pressure and open the flood-gates are logically indicated. Nitroglycerin is the agent commonly used for this purpose. Allow me again to suggest that this drug does just what we desire in this direction but it only accomplishes in this one-half the indication, it does not stimulate or tone the heart. The employment of trinitrin in acute diseases accompanied by cardiac failure is to me irrational for it cannot in these conditions aid in any way a weakened heart-muscle. It should be restricted to those cases attended by obstruction due to high arterial tension, and used in conjunction with those drugs heretofore mentioned, which are essentially tonics or stimulants, often with opium and its alkaloids. Morphin is tonic to the heart, and it quiets the nervousness so often present. The bromids and valerianates are often valuable in these cases. No better combination than morphin, strychnin and nitroglycerin can be employed in acute attacks, especially those which we designate as angina pectoris.

Strontium bromid and iodid have been in my hands quite as effective and less liable to disagree with the stomach than those of potassium and sodium. In conclusion, iron and arsenic, as tonics, combined with a diet calculated to the same end, are not to be lost sight of in building up a weakened and degenerated muscle. The change in the capillary system, having once taken place, cannot be removed, but the propelling power of the heart may be made compensatory.

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10 Vestry Street

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### Clinical Lecture

*Delivered at the Western Reserve Medical College, May 5th*

BY DR. W. H. HUMISTON

*Associate Professor of Gynecology in the Medical Department of the Western Reserve University*

THE first two cases which I wish to present to you today very nicely illustrate several phases of pelvic disorder, contrasting the necessary procedures requisite for their relief.

Case I. Sadie H., age 25 years, single, one child born five years ago with normal labor—no miscarriages. Family history negative. First menses began at fourteen, regular, not painful, lasting usually three days, but scant in quantity. She has had typhoid-fever and measles. She never had any difficulty of micturition, but has occasionally had incontinence of urine. The urine is highly colored and at times scanty. She complains of frontal headaches, and at times sick headaches with vomiting, pain in the back, severe pains in either groin, worse on the right side. Menstruation had been regular until seven months previous to this time when she suffered with dysmenorrhea and menorrhagia. Within the past two months she has much more pain and metrorrhagia, flowing three times in a month. She has chills and fever. The patient is losing in weight and is exceedingly nervous. She has a profuse mucopurulent discharge. She has had several acute attacks of great pain through the lower part of the back, but has not been compelled to stay in bed longer than a day or two.

**EXAMINATION.**—The patient appears sallow and pale, with dark circles under the eyes. General physical examination of the chest and abdomen is negative. Temperature, 99.6 degrees.

**PELVIC EXAMINATION.**—There is a relaxed vaginal outlet, a mucopurulent discharge, the vagina is reddened and sore, and the cervix is enlarged and lacerated. The uterus is in slight retroversion, enlarged, exceedingly tender on pressure, and motion in the body is very much impaired. There is a feeling of resistance in the left vaginal vault, and the patient flinches when pressure is made in this region, but the true condition of this appendage cannot readily be determined. In the right vault, however, we find a mass, which, upon careful palpation, discloses a large ovary and an enlarged tube. This mass is adherent to the adjacent parts. You will notice that the most exquisite pain is caused by the slightest manipulation. A differentiation of the ovary and tube within the mass can be made. The tube overrides the ovary and encircles it along its outer border, a deep sulcus intervening. The resistance (the tension) is much greater in the ovary than in the tube. The ovary is approximately the size of a hen's egg, and the tube is as large as an ordinary sausage, probably three quarters of an inch in diameter.

This examination reveals sufficient data to determine the diagnosis without the hazard of general anesthesia and without giving the patient more pain than is bearable. I believe, therefore, we can here make a positive diagnosis of pyosalpinx, with probably an ovarian abscess, of the right appendage. The prognosis and treatment we will discuss in connection with the second case.

Case II.—Kate B., age 43 years, married twenty-two years ago, has borne eleven children, the age of the youngest being eleven months. She

has had no instrumental deliveries, but all of her labors have been exceedingly long and hard. She has had no miscarriages. The catamenia commenced at the age of fifteen years, were regular, always painful, and of average duration and quantity. She has had typhoid-fever and rheumatism. She presents the history of a possible puerperal fever occurring twelve years ago, succeeding an especially difficult labor, which required some manipulation on the part of the attending physician. She has never been quite well since that time, but has borne several children. Family history reveals nothing pertinent to the case. Four of her father's family were insane.

Micturition is too frequent and is at times painful and burning. She complains of too frequent menstruation, attended, however, with but little pain, vertical and occipital headache, a bearing down with a sense of loss of resistance, and a profuse leucorrhea. The stomach is weak and appetite variable. She is nervous and fears insanity. One day she feels quite well and the next day miserable. She has lost considerable in weight, but not recently. Her bowels are costive, and she suffers from rectal irritation, straining at stool, and has hemorrhoids. On questioning the patient we find she is very irregular in her mode of living generally, eating at all hours during both day and night, and drinking immoderately of well-steeped tea.

Examination of the patient reveals the following: There is a partial rupture of the perineum, the tears being bilateral. The vagina is relaxed and there is a prolapse of the anterior vaginal vault. The cervix shows a large gaping tear along its left lateral wall, and is hard, cystic and eroded. The uterus is in about the normal position, enlarged and very hard, and you see she gives evidence of considerable pain when we use the bimanual method of examination. The mobility of the uterus is somewhat impaired, although we find no resistance along either side of the body. The pouch of Douglass is free. The appendages, palpated only after some effort, appear to be normal, and the pressure elicits no particular tenderness.

Here then, we have a woman who has borne rapidly and with great difficulty eleven children in twenty-two years of married life, with a history of possible peritonitis, and who, upon examination, presents no gross lesions of the appendages, but a large and exquisitely sensitive uterus whose walls are very hard. The diagnosis in this case is a chronic endometritis, with inflammatory changes in the walls of the uterus itself.

Let us consider the treatment of these cases. In general both should immediately be instructed to live hygienically, taking extreme care as to the quality and quantity of food to be eaten, and the proper time for its consumption. They should rest from their ordinary labor and spend at least twelve hours of the day in bed. Long douches of plain hot water or a teaspoonful of borax or soda to the pint of water should be taken in the *prone position*, twice each day. Total abstinence from tea and coffee should

be enforced, and a glass of hot water taken an hour before each meal and at bed-time, with also the administration at these times of ten grains of potassium bitartrate, or a quarter of a teaspoonful of a mixture of equal parts of baking soda and common table-salt. This combination of water and salts is a most bland and efficient diuretic. Three times a week or oftener an ordinary cotton tampon, carrying a solution of boroglycerol, or a ten per cent. solution of ichthyol in glycerin, should be inserted into the vagina. These are quite efficient in relieving pain and congestion, and also the sense of weight in the pelvis.

Will ordinary medicinal or hygienic measures cure our patients? No. I have purposely selected these two cases to contrast what may and what may not be achieved by minor operative gynecologic procedures. I am sure you all recognize that every indication in the first case points to a celiotomy, with a removal of the diseased structures.

And here I will impress upon your memories several "don'ts" in connection with Case I. The gentlemen of my class who have just examined the patient have very ably ascertained the relative position and size of the uterus by bimanual manipulation. Then *don't* use a sound, as it is a useless and dangerous instrument and might in this case do irreparable harm. *Don't* curet the uterus even as a proceeding preliminary to a later major operation. I scarcely need point out the possible immediate dangers and the positive chance of making worse the existing pelvic disorder. While I believe such uteri require curetting, it should immediately precede the opening of the abdomen. I therefore advise in this case thorough curetting of the uterus and the removal of the diseased structures at one sitting. The prognosis is certainly most unfavorable without such operative interference, and her chances of ultimate recovery with operation are good, excluding, of course, the slight risk (about 5 per cent.) following the operation.

It is such cases as the second, gentlemen, that minor operations alone are indicated. After the patient's general condition is improved, and you feel that ordinary means, *i. e.*, douching and tamponading, have to some extent at least relieved the congestion and tenderness, then advise a curetting of the uterus to be followed by repair of cervix and perineum, the two latter taking place at least two weeks following the former, and at one sitting. The condition of the rectum should be considered of no minor importance. Oftentimes simply over-stretching of the anal sphincter is quite enough to give relief, but it is my practice to endeavor to put the passage in the best possible condition. This frequently means the complete removal of all hemorrhoidal tumors, both large and small, together with sensitive tabs, resulting from a collapse of old hemorrhoids. In this operation I prefer the use of the clamp and ligature, from which I have obtained most satisfactory results.

The prognosis in this case is very favorable. The curetting can be very easily performed under cocain and then under a general anesthetic the cervix, perineum and rectum can be repaired at one sitting. Let me insist upon the necessity of first securing a small uterus and a healthy *mucosa* before attempting a repair of the lacerations.

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## EDITORIAL

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### Defective Cerebration at Atlanta

THE action of the American Medical Association in excluding the members of the Cleveland Medical Society requires a few words of comment, but no more than a simple statement of the facts in the case. The Cleveland Medical Society has wished to appear, as it undoubtedly is, one of the most progressive and enlightened medical societies in the country. It ventured in declaring its allegiance to the code of the American Medical Association to affirm its belief that that code was broad and humane in its letter as well as in its spirit. To this statement in our constitution, exception was taken by some members of the Association as well as some members of the State Medical Society, who thought that the Cleveland Medical Society should

simply adopt the code of the American Medical Association without comment. This the society has, in the past year gladly done. It is needless in this place to discuss the question whether the framers of the Code of Ethics had in their minds when they worded it any special man or set of men whom they wished to exclude from their organization. The spirit and wording of the code are liberal. They exclude no one who can show a legal diploma and who practices rational medicine. This has been distinctly stated, not only by members of the Cleveland Medical Society and of our state society, but by a member of the council of the American Medical Association on the floor of the Cleveland Medical Society. The fact that our constitution conforms in all respects to the code of the Association was sent in writing to the president of the council before the Atlanta meeting. Two members of the society were sent to that meeting with marked copies of our constitution. The fact of our action in removing a harmless clause which has been objected to was perfectly well known to the council of the Association. In spite of all this, the council suspended for a time the members of the Cleveland Medical Society from membership in the Association. The obvious inference is that we were suspended because we now conform to the code. We prefer to believe, however, in charity to the council, that they were hoodwinked and led by the nose in this matter. The fact that the Association has for two years received dues from members of the Cleveland Medical Society, that it has then suspended them from membership and has failed to refund their money adds to the dramatic interest of the situation. It does more, it points clearly the necessity of such revision of the constitution and mode of organization of the Association as shall make it at least a difficult matter for mere wire-pullers to exclude from the society a large body of its most active workers. It is hardly credible that a body of men who are at least supposed to represent the brains of the medical profession of America should, after a presentation of the plain facts in this case, take an action which throws a direct slur on their own code, and so clearly stultifies them in the eyes of the world. The X Rays are said to penetrate all known substances of whatever density. We believe they have not yet been tried on the skulls of the council of the American Medical Association.

## High Ethics on the Lake Shore

WE are interested to notice in the *American Medical Compend*, published in Toledo, an editorial note on the JOURNAL. The *Compend* refers to the high stand taken by the *Western Reserve Medical Journal* in the question of drug advertising, but objects that its editors "undertook to criticize some of the most ablest journals in the country for publishing articles with special reference to certain reliable manufacturers." We must plead guilty to this indictment. We thought and still think the previous standing of a journal no extenuation of an offense which is becoming every day more common. When, however, the editor of the *Compend* continues that "after the absorption of the now defunct medical journal, the editor or manager has issued in the new born articles which the editor or his faculty constituents (*sic*) opposed," we must enter a mild protest. If we rightly apprehend the meaning of the sentence quoted we are charged with publishing "articles in reference to certain reliable manufacturers." This we cheerfully admit is true as regards our advertising pages, but we have not followed the lead of the *Compend* and of other "most ablest journals," in running advertisements as original matter, or in the form of insets. Continuing, the *Compend* remarks: "The tune, as you will observe, is changed, and the *Cleveland Journal of Medicine* is scrambling with both feet to publish anything which would refer from a spit-box to a window shutter." If we have really changed our policy and publish the same advertisements as does the *Compend* we are glad to have the fact pointed out, as we were not aware of it. However, on looking over our advertising pages we are unable to find in them such advertisements as those of the "Pil Orientalis," the "Organic Stricture Cure" and the "Amick Cure," which appear in the *Compend*, and to which its editor may possibly refer; so that although we are gratified for the suggestion we are sorry that it was not made with more definiteness of detail. We hope the *Compend* will continue its interest in these ethical questions, and its friendly censorship of our pages and those of its other contemporaries.

The JOURNAL believes in a high standard in practice as in theory, and is especially rejoiced to see such a journal as the *Compend* come out strongly in favor of the theory of purity in medical journalism.



### The Ohio State Medical Society

HAVING last year passed its Semi-Centennial in honor the Ohio State Medical Society meets this year under most favorable auspices.

Largely through its efforts a medical practice act is at last upon the statute books and the members of the Society and of the various local societies, which also did so much for the measure, will have good reason to gather in large numbers at Columbus and exchange mutual congratulations. This alone should make the 1896 meeting an unusually large one.

Some members of the Society propose to have Columbus made the permanent meeting place. While it is freely admitted that the central location and ready accessibility of Columbus are much in its favor, there are other factors which render it very desirable for the Society to remain a migratory body. The burden thrown upon the local profession of Columbus year after year is unjustly severe. While meetings in other cities are at times not so large, they do much to stimulate the profession of the cities thus favored to better work. With a permanent location in any city there is very great danger of the Society becoming somnolent. The fact that one or two meetings at Columbus are so successful is not a safe premise from which to conclude that all future meetings there will be as good.

Abandoning generalities, the Cleveland Medical Society, and indeed the whole profession of Cleveland have extended to the State Medical Society a cordial invitation to meet in Cleveland in 1897. The profession of this city wishes to show its brethren of the State the charms of the Forest City and the thorough-going hospitality of its medical profession and citizens in general.

To the Ohio State Medical Society Cleveland extends a most cordial invitation to meet within its border next year and the Cleveland Medical Society guarantees to the visitors a most hospitable welcome.

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THE latest epidemic is not of germs but of germicides, and mainly of the antitubercle variety. It has swept from Berlin to Kansas City, nay, to Tokio, and China is believed to be the only country so far exempt. The problem itself is a very simple one. There are very strong antiseptics to combat small and feeble germs of known habitat and domestic habits. The judicious application to new remedies of what theologians call "the higher criticism," or in other words common sense, may be useful. Antitubercle serum is obviously an imitation of the antitoxic serum used against diphtheria and tetanus; these are selflimiting diseases, the other is not; its usefulness is still to be proved. The method which comes to us from Tokio and the one which has lately sprung into being in New York, consist apparently in the use of one of the old familiar antiseptics as a hypodermic injection.

tion. It is sufficient to say that this antiseptic has already been thoroughly tried by the stomach and its advantages by hypodermic injections are not at first sight obvious, and are still unproved. The latest method from Berlin consists in the use of ozone, one of the most irritative of substances. It must be a superior method indeed which brings ozone into contact with the bacteria and leaves the lung tissue untouched. It is possible that a successful method of treating tuberculosis will one day be discovered; if so, let us hope that the active agent will not be called either microcidia or bakteroklastin.

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FOR a time the study of the X Rays seemed to add little to the original discovery of Röntgen. There are already, however, signs that their field of usefulness will be much wider than the photographing of the skeleton and the finding of bullets. Dr. Francis H. Williams has recently made an interesting series of experiments with a fluoscope, reported to the Suffolk District Medical Society of Massachusetts. He discovered several bullets in the skull, which marks a very distinct advance in brain surgery. He finds, which is still more interesting, that diseased lung-tissues show darker than sound lung-tissue. The upper border of the liver and its motion with respiration were clearly seen and corresponded with the border as made out by percussion. The outlines of the heart are distinct against the more penetrable lung-tissue.

Mr. Charles L. Norton, of the Massachusetts Institute of Technology, has mapped out the spleen, which is clear as compared with the other more opaque abdominal organs. He was successful in diagnosing an enlarged heart, pneumonia and tuberculosis. It may be many years before the method will be very accurate; it is thus far the only way, except by necropsy, of making lesions visible.

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A commendable innovation is noticed in the announcements of the meeting of the State Medical Society in regard to the Annual Banquet. Heretofore the Banquet has been a local function, depending for its occurrence upon the exigencies of the local committee of arrangement, and falling heavily in expense upon the local profession. It is most desirable that the Annual Banquet should be a function of the State Society itself, the expense to be borne by the members in attendance. The fee for the Banquet at this meeting—one dollar—is very moderate and will be willingly paid by the members of the Society, who will be glad to relieve the Columbus physicians of the burden which fell upon them last year. It is to be hoped that from this time on the Annual Banquet will be a regular feature of each year's meeting, that the Society itself shall control the time, place and arrangements for it, and that the expense shall fall upon the members of the Society.

## OBITUARY

In the early morning of the 5th of the present month Dr. W. J. Scott finished his earthly career and passed over to the silent majority. He had been in failing health for some years, but continued in the active practice of his profession until the winter of 1894 and '95, when he was obliged to give up work entirely. He was confined to his home for many weeks, but in the summer of 1895 he regained his strength sufficiently to enable him to take up a part of his practice again, and he continued to do a moderate amount of work until early in February of the present year, since which time, to the time of his death, he was confined to his home and most of the time to his bed. The cause of his death was heart disease, dilatation having existed since his illness in the winter and spring of 1895. His illness, and the suffering attendant upon it (which at times was severe), were borne with that calm fortitude so characteristic of the man. And, although he knew his disease to be a mortal one, he met its varying aspects with a courage that was truly sublime, and when the end finally came it was evidently no surprise to him, for he had had, from the beginning, a thorough comprehension of his case, and knew perfectly well what the final result must be.

William Johnson Scott was born in Culpepper Co., Virginia, January 25th, 1822. His grandfather was a Scotchman who came to America before the Revolution and served in the Continental Army. His father, John Scott, and his mother, Mary (McKenna) Scott, were natives of Virginia, where they lived until William was ten years old, when the family moved to Ohio and settled in Knox County. About two years later the father died, leaving a widow and five children, of whom William was the oldest. The means of the family being extremely limited, their home was broken up and William was received into the family of an uncle who lived in Knox County. Here his life was doubtless that of the ordinary country boy, but he must have made good use of his time, for although he had to work as the ordinary country boy must, and had only the district school in which to get an education, we find him fitted at the age of 21 to enter Kenyon College, which institution he entered in 1843 and from which he graduated in 1848. He paid his own expenses in college, to do which he worked diligently at whatever his hands could find to do. Some years ago, while the writer was on a visit in Knox County, he was shown a large barn which William built during this period of his life, superintending the construction and doing most of the carpenter work himself, and it may be remarked in passing that the structure was well built and looked as if it would stand for many years to come. At this period he was employed in a wash-board factory, and while his hands fashioned the wash-board, his mind was unraveling problems in mathematics, and he has been heard to remark that his mathematics were literally rubbed out on a wash-board.

Graduating from Kenyon College in 1848 he at once began the study of medicine with Dr. Homer L. Thrall, then of Gambier, but later of Columbus, Ohio, a man of whom Dr. Scott always spoke in terms of great respect as being a man of great learning and far in advance of the profession of his day, especially in diseases of the nervous system, and it is believed that it was Dr. Thrall who first awakened in young Scott's mind that strong interest in nervous diseases that continued to the end of his life.

Directly after graduating from Kenyon College he was employed as tutor in the college, probably at the same time pursuing his medical studies. His first course of lectures was taken in the old Cleveland Medical College in 1849 and '50. Returning to Gambier, he resumed his studies, practicing at the same time, as was the custom in those days. About 1851 or '52 he went south and for one year taught chemistry and geology in Jefferson College, near Washington, Miss.; returning he attended a second course of lectures at Starling Medical College, Columbus, graduating in 1855. After practicing for a time in Knox County he moved to Sharkville, a small town a few miles south of Columbus. While there he married, in November, 1858, Miss Mary Stone, daughter of Nathan Stone, of St. Johnsbury, Vt. When Charity Hospital Medical College was organized in Cleveland in 1863, Dr. Scott was called to the chair of *Materia Medica* and Therapeutics, which he held for several years, when he was transferred to the chair of Medicine and Clinical Medicine. This he held until 1880, Charity Hospital Medical College some years previous to this time having become the medical department of Wooster University.

In 1880 an attempt was made to unite the two medical schools, and at this time Dr. Scott was elected a member of the faculty of the medical department of Western Reserve University, with which institution he was connected until his death. For several years he had been Professor of Medicine and Clinical Medicine. Dr. Scott was deeply interested in medical societies, and was a member and frequent attendant upon all the local State and national societies. He took an active interest in the organization of the Cleveland Medical Society and was its first president. He was connected with many charitable organizations and was one of the originators of the Bethel Associated Charities of this city. Being greatly interested in sanitary matters he accepted a position on the Cleveland Board of Health, which he held for nine years, and during this time, although he was actively engaged in the practice of his profession, he found time to give a great deal of attention to the duties of his position, and the influence he exerted was always in the direction of improved sanitary conditions and for a better and more efficient health department. Of the four children born to Dr. and Mrs. Scott only one, Dr. N. Stone Scott, survives.

For more than thirty years Dr. Scott has held a prominent position in this community, and the universal testimony now is that he was a great man;

great, not only as a practitioner of medicine and a teacher of medical science, but a great man, one who possessed the true elements of greatness: a desire to know what is the right and a courage to do the right when known. His mental attainments were of a high order, his ability to impart knowledge to others far above the ordinary, and his conception of the duty of the individual to the community and to the State was such as, alas! too few possess. But these did not make him great. His real greatness consisted in his firm belief in and desire to know the truth and the right, his willingness to sacrifice himself for his fellowmen and his deep sympathy and his broad charity, which made him the friend of all, the enemy of none. Dr. Scott was a man of great modesty and perfectly unassuming manners, and yet he was a man of great selfreliance. His early training had made him so; even when a boy he had to make his own way and decide questions for himself, and the habits thus formed stood him in good stead in after life. This selfreliance came, not from egotism, but from a consciousness that he possessed a thorough knowledge of the particular case in hand and that he could safely rely upon that knowledge, and those who knew him best knew how infrequently that reliance was misplaced.

He was a man of deeply sympathetic nature, and to this hundreds of people to whom he has ministered in times of sickness will willingly testify. In the sick-room he was a tower of strength, on which the sick and weak could lean and find support.

Dr. Scott was deeply religious by nature, and his religion entered into his everyday life. He was eminently a social man, yet never a society man in the ordinary acceptation of the term; but his great learning and broad culture made him a delightful social companion, and no one ever came from an hour spent with him without having learned something, nor without the feeling that he had met a remarkable man. He was a many-sided man as evidenced by his interest in subjects outside of his profession. He was a member of the Society for the Advancement of Science, the American Pharmaceutical Society, and many other organizations not strictly medical in character. He was also a many-sided physician, a safe consultant in any case, and thus a good example of a "physician of the old school," who in these days of specialism is becoming lamentably rare.

"He was a man; take him for all in all,  
I shall not look upon his like again."

A memorial meeting to Dr. W. J. Scott was held on the evening of May 11 by the physicians of Cleveland. The meeting, while not large, was representative, and many physicians gladly availed themselves of the opportunity to publicly express their admiration for the great man, who had just passed away. The meeting was felt by all present to have been a very profitable one and Dr. Scott's memory was fittingly honored. The following are among those who spoke at this meeting: Hon. M. A. Foran, Drs. H. H. Powell, C. F. Dutton, B. W. Holliday, P. H. Sawyer, H. W. Rogers, H. S. Straight, W. A. Knowlton, W. H. Humiston, O. B. Campbell, M. Rosenwasser, R. M. Woodward, O. T. Thomas, G. W. Crile, W. E. Wirt, P. M. Foshay, S. W. Kelley, J. G. Spenser, J. J. Nungesser, J. E. Cook and H. J. Lee. Dr. Cook was chairman of the meeting and Dr. Straight, secretary.

**Dr. Peter Ignatius Spenzer**, of 370 Central Avenue, died at his home at noon Monday, April 27, after an illness of only a few hours. He was a well-known physician and druggist of this city and was only 59 years old. Dr. Spenzer was born in Aschhausen, Wurtemberg, Germany, in 1837. He came to America in 1853, residing short periods in New Jersey, and in Pittsburg, coming to Cleveland in 1857. He was a hospital steward at the barracks in Louisville, Ky., during the war, but was retired because of heart disease. Coming home he studied medicine along with the resumption of his pharmaceutic work, and graduated from the Wooster school in 1871. For 25 years he was visiting physician to the Home of the Little Sisters of the Poor. He took a prominent part in the pharmaceutic affairs of the city and state. Dr. John G. Spenzer, lecturer on pharmacology in Western Reserve University is one of the six children who, with a widow, survive the deceased.

**Dr. Albert Hoover**, of Akron, died May 15 at Cambridgeboro, Pa., where he had gone early in the month in the hope of regaining his health. His death resulted from a very peculiar accident. While lying on a lounge, playing with one of his children, the child trod upon his testicle. In a few days an abscess formed, which was opened, the surgeon advising prompt removal of the diseased testicle, but the advice was rejected. Septicemia supervened, and the patient went to Cambridgeboro hoping for relief, but death soon ensued. The immediate cause of death is said to have been spinal meningitis.

Dr. Hoover was born August 23, 1859, at Canal Fulton, and was therefore 37 years of age. He was a graduate of Wooster University in 1880, and of Jefferson Medical College in 1884. His practice was limited to diseases of the eye and ear. He leaves a widow and three children.

At the time of his death he was President of the Celsus Club of Akron, and corresponding secretary of the Union Medical Association of Northeastern Ohio.

**Dr. John A. Knowlton**, a graduate of the Medical Department of Western Reserve University in the class of 1846, and one of the best known physicians of northern Ohio, died May 18 at his home in Akron. He was 73 years old and still actively engaged in practice, of which he had just completed his fiftieth year. Death was due to apoplexy.

Dr. Knowlton was born in Brandon, Vt., lived in Kent for a time, and had made Akron his residence for the past 40 years of his life. He leaves one child, Dr. Frank W. Knowlton, dentist, of Akron.

**Dr. Emmett H. Kirk**, of 299 Crawford Road, died suddenly of cerebral tumor Sunday May 10. An operation two weeks before his death, while relieving pressure symptoms, failed of permanent benefit. Dr. Kirk has been for 12 years a resident of Cleveland, having been in the insurance business until two years ago. He leaves a widow and one child, a daughter.

### Our Columbus Letter

THE arrangements that have been made for the meeting of the State Society should secure a large attendance. The Committee of Arrangements have looked carefully after the details of the meeting, nor have they neglected the social features, which will equal those of last year.

With the advent of hot weather the people of this city are having their attention directed to the urgent need of a better supply of water. The city at present receives its supply from the Olentangy River, and, as the city extends a distance of nearly two miles above the point of intake, and as the banks of the river are subjected to no police regulations, the water is never free from organic matter. In hot weather, when the river is low, the water passes directly from the river to the service mains of the city. During the hot months of last year the supply of water was nearly exhausted, and the danger of complete exhaustion was greater than our people realized. The recommendations of the present health officer provide for the building of a dam across the Scioto River at a distance of some miles above the city, where the river lies between high banks, so as to impound its waters. From this dam he proposes that it shall be conveyed to the present intake through the open channel of the river, the banks of which are to be straightened. This plan will involve an expenditure of less money than probably any other that has been proposed, but it is scarcely more than a temporizing measure. The dam itself is not free from danger of destruction by floods, and unless the banks of the river, both above and below the dam, can be kept free from deposit of sewage, its water will be scarcely safer than that from the present supply. The city should have a reservoir where water enough can be stored, secure from accident and contamination, to supply a population of 200,000 people for a period of sixty days.

The physicians of the State are registering quite rapidly in compliance with the new law. About 6,000 have already registered, and about 2,500 more have yet to comply with this act. Thus far the Board has not taken up doubtful cases. These will probably be reserved until most of the work is completed. Some amusing incidents occur. One physician sent his diploma to the Board, enclosed in a tin box; this was enclosed in boiler plate, and this in turn in a wooden case. Another one sent his diploma carefully packed in a box on which was tacked a five dollar bill, the necessary fee; this box was then enclosed in still another, and shipped by express. Few physicians have indicated an unwillingness to comply with this law, although some of them have declined, in addition to the affidavit which is required, to furnish the diploma as proof of the statements contained in the affidavit.

Efforts are now being made to obtain money with which to erect the

new buildings for the Protestant Hospital, projected some time ago. A considerable apathy exists among the people concerning the needs of this hospital, due, probably, to the fact that it is largely a denominational institution. However, it is a worthy charity, and the committee in charge of raising the funds should be successful.

It is said that the Medical Colleges are re-arranging the curriculum of study so as to cover the extended course of four years. -

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### Our Buffalo Letter

THE season of college commencements is upon us. The Medical Department of the University of Buffalo held its commencement exercises Tuesday, May 5th, while the medical department of the Niagara University held its commencement on Tuesday, May 12th. The alumni exercises of the latter were held in the afternoon, when the following program was presented: "Involuntary Intoxication from a Medico-Legal Standpoint," Sidney A. Dunham, M. D.; "Treatment of Retrodeviation of the Uterus," C. E. Congdon, M. D.; "Some Heart Lesions and their Treatment," D. L. Redmond, M. D.; "Treatment of Puerperal Convulsions, with Report of Cases," L. G. Hanley, M. D.; "Puerperal Eclampsia, with Report of Cases," J. S. Peterson, M. D.

The graduating exercises were held in the evening at the Star Theater, where addresses were delivered by Dr. Herman Mynter and Bishop Mallien. Diplomas were granted to 14 candidates. The banquet at the Genesee was well attended, and thus ceased a very successful college year.

The Alumni exercises of the Medical Department of the University of Buffalo were of more than usual interest, being the celebration of the 50th commencement. Henry J. G. Garrigues, M. D., of New York, read an interesting paper on "Colpoperineorrhaphy," which was followed by ten minute discussions on the subject by Dr. Eugene A. Smith and Dr. Charles H. Richmond. Max Einhorn, M. D., of New York, presented a paper on "The State of the Gastric Mucosa in Secretory Disorders of the Stomach." The paper was discussed by Dr. Charles G. Stockton, Dr. Allen A. Jones and Dr. A. L. Benedict. Dr. Robert T. Morris, of New York, also presented a paper which was discussed by Dr. M. D. Mann and Dr. C. C. Frederick. "Some Notes on Coronary Arteries," was the subject of a paper by George Dock, M. D., of the University of Michigan, at Ann Arbor, discussed by Dr. H. R. Hopkins and Dr. Delancy Rochester. The papers were most of them illustrated with either blackboard sketches or specimens.

The graduating exercises were held at Music Hall in the evening, every seat in the vast auditorium being taken long before the hour of commencing. Diplomas were granted to 54 candidates in the department of medicine, 25



in the department of pharmacy, and 12 in the department of dentistry. Three lady students received medical diplomas. Addresses were delivered by Chancellor J. O. Putnam and Mr. Joseph A. Connor. The banquets held by the different departments were well attended and highly enjoyed.

The *Buffalo Medical Journal* makes an important editorial announcement to the effect that the present board of editors will resign their respective positions and give way to the demands and exigencies of the times. The *Journal* will not suspend publication, but will allow the women physicians of Buffalo and vicinity to publish a *woman's number*. This is, we believe, the first time in the history of medical journalism that a woman's edition is to be published and the experiment will be watched with much interest. June is the lucky month chosen. Needless to say the old staff will resume operations in July.

The American Orthopedic Association will hold its tenth annual meeting at Buffalo, Tuesday, Wednesday and Thursday, May 19, 20 and 21, under the presidency of Dr. Royal Whitman, of New York. A very elaborate program has been prepared by the secretary, Dr. John Ridlon, of Chicago.

Word has been received that Dr. William Warren Potter has been elected an honorary member of the American Academy of Medicine at its recent meeting held at Atlanta.

Dr. Woods Hutchinson has been chosen lecturer on Comparative Pathology and the Ancestry of Disease in the Medical Department of the University of Buffalo. Dr. Hutchinson was formerly Professor of Anatomy in the Iowa State University.

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### Our Pittsburg Letter

THERE is a newspaper report to the effect that Mr. H. C. Frick, of the Carnegie Steel Company, is to erect, upon Squirrel Hill (one of the most beautiful sections of the city), a children's hospital at a cost of \$500,000 and place it under the care of the Episcopal Church.

St. Francis Hospital is making additions to its building which will enable it to accommodate about 75 additional patients. This hospital has a wing for insane patients, accommodating about 80 or 90, and it is nearly always comfortably filled. Many persons unhesitatingly send their insane relatives here who would greatly dislike to send them to one of the state hospitals for the insane. The one institution, they argue, is a "hospital," the other, an "asylum." I would not, however, for a moment, contend that patients receive any better strictly *hospital* care in St. Francis than they do in the state institutions for the insane. Apparently it is the very fact that St. Francis is not *exclusively* a hospital for the insane, that makes it seem to many persons less of a hardship to send a person there than to a state hospital. To say that

a person is being treated at St. Francis does not necessarily mean that he is insane; to say that he is at one of the state hospitals does mean so. I believe it would be well if at least one general hospital in each large city would provide a specially equipped wing for insane persons. It would result in a larger number of patients of this kind being early brought under hospital treatment than at present.

The subject of insanity brings up to my mind a lunacy inquiry which occurred last week where the findings of the jury were a surprise to the physicians who had examined the patient. The testimony of three physicians (two of whom are specialists in mental diseases, and the third of whom is one of the best known and most careful general practitioners in the city) brought out these points concerning the subject of the inquiry. He is a man about 60 years of age. In general conversation on indifferent topics he gave no evidence of insanity. He, however, believes that his wife (a woman of 50) is unfaithful; that she is frequently visited by other men; that her own son has frequent sexual intercourse with her; he frequently charges his wife with infidelity in the presence of his children; he had stuck pins in the carpet in front of the bed-room door in such a manner that they would be knocked down by the opening of the door; all the windows in his bed-chamber were nailed down by him to prevent men from entering the room to have intercourse with his wife.

No attempt was made to show that his suspicions were well-founded. These three physicians testified that the man was insane and that he should be placed in an asylum because: (1) he might do violence to his wife or (2) to some man whom he might suspect of having improper relations with his wife; (3) the disputes in which he charged his wife with infidelity had a bad effect on the morals of his minor children in whose presence these disputes often occurred.

The jury found that the man was not a lunatic *but recommended his separation from his wife!*

The following is the verdict:

"That said \_\_\_\_\_ is not a lunatic; but that he is at times dangerous to his wife, \_\_\_\_\_, and that in their opinion, to avoid danger to her life, he should be restrained or put under stipulation or promise to remain away from her, his said wife."

The Pittsburg Dental College, which was recently organized as a department of the Western University of Pennsylvania, has secured a charter and expects to begin operation in the fall. The course will cover three years, and in other respects conform to the requirements of the Dental College Association. The dentists, who are to be the teachers in the college, are among the best known in this community, and there can be little doubt that the college will start on a high plane. It is said that it will open with over 50 students. There is no other dental college here.

The Medical Department of the Western University of Pennsylvania, it is expected, will decide shortly upon plans for an extensive addition to its building.

Dr. E. G. Matson recently took charge of the Pittsburg Bacteriological Department.

Allegheny has just organized a Bacteriological Department which has been placed in charge of Dr. Burns.

OFFICIAL PROCEEDINGS  
OF THE  
Cleveland Medical Society

REGULAR MEETING, APRIL 24, 1896

*The President, DR. COOK, in the chair*

Presentation of Cases and Exhibition of Specimens

DR. H. S. STRAIGHT

*A Case of Epithelioma of the Tonsil*

I have here a case of epithelioma of the tonsil. I saw this case three and a half weeks ago. He first noticed a slight enlargement of the tonsil about March 1st, 1896. He gives a specific history, and I gave him at first potassium iodid and mercury. He was somewhat improved at the end of a week. At the end of the second week I removed a small portion of the tonsil and it was examined microscopically. This disease is particularly rare. Different forms of carcinoma occur in the pharynx, but the disease most often attacks the tonsil. In a little over eight thousand cases, only three are reported of the tonsil. There is a case of cancer of the tonsil at the infirmary, so that there are probably two cases in Cleveland at the present time. The outlook is about as dark as can be. The disease is sure to recur, and it is a question whether a radical operation should be made. It is claimed by some observers that removal of portions of the tonsil with the galvano-cautery, or by other methods, contributes to the comfort of the patient and does not stimulate the growth. A great many men believe that the more you interfere the more rapidly the tumor grows. Some few cures from radical operation have been reported. The question ought, it seems to me, to be submitted to the patient with a fair statement of the risk involved and the faint hope of any radical benefit.

DR. W. T. CORLETT: I wish to call attention to electrolysis in the removal of malignant growths. My faith in it was not strong at first, but having had very good results in small affairs, the method was pushed still further. I have removed a great many well-developed epitheliomata, and so far have not had a single recurrence. I think it is better and more radical than the knife, because it not only destroys the growth itself, but finds, in the channels through which absorption takes place, the best conductors of the electric current. The method would be especially applicable in epithelioma of the tonsil, if used early.

DR. STRAIGHT, (in closing): The glands of the neck are not much enlarged as yet. In the opinion of the leading authorities, no matter how early discovered, the growth will recur, even if radically removed. The external operation is one of considerable magnitude.

DR. G. W. CRILE

*A Case of Fracture of the Radius*

I wish to report a case of fracture of the radius, of which Prof. Miller made an excellent skiagraph. The lower fragment was displaced downward. The fracture was caused by falling from a carriage, striking upon the extended hand. The line of fracture was above the *pronator quadratus*. I had a fair chance to reduce it, but could not do so. I cut down on the radius and found good reason for failure. The lower fragment was so firmly forced down under and in front of the upper fragment that it was very difficult even in the operation, when the bones were exposed, to raise the lower fragment. Even when done, the line of fracture being from above downward and forward made it absolutely impossible to keep it in place. I therefore found it necessary to cut off the ends of both fragments. When this was done I raised the lower fragment by forceps and engaged it with the upper fragment. There was also a green-stick fracture of the upper fragment about two inches above its lower end. This was not shown in the skiagraph, except by a slight bending. Before operating I prepared to wire or to use some sort of mechanical support, but after cutting off the broken ends of each fragment and bringing them in apposition so that they were firmly locked together, nothing more seemed necessary. There has not been any difficulty in holding the fragments in place.

DR. W. E. WIRT: I would like to ask Dr. Crile how much shortening, or apparent shortening, he got as a result of the resection. I have fractured the tibia, without fracturing the fibula, in cases of bow-legs, with the result of actually increasing the length of the leg; the fibula helped to hold the fragments apart, and the space filled up with bone tissue.

DR. CRILE: I would say in reply to Dr. Wirt's question that in this case fortunately the arm was a little lengthened from what it was before the operation. In the heavy fall upon the pavement the lower fragment was driven upward behind the upper fragment and that forced back the wrist and deflected the hand toward the ulnar side. At the time of the operation I did not resect the bone at the point of entire diameter; I cut off the part of the fragments opposite each other at a point at which I could hold down the fragments.

I would like to say that fracture of the radius presents one of the most difficult problems. You cannot control the muscles. The ulna may help you or may oppose you. It may either be a strong ally or a very bad foe.

I had one case of a similar kind which I placed under anesthesia, a case of oblique fracture, in which Dr. Bunts, Dr. Lower and myself made an effort to reduce. Our best efforts were unsuccessful in properly reducing that fractured radius, and the reasons are perfectly plain when we see the Röntgen photograph. If the direction of the obliquity is from above downward and inward then you will have no difficulty. But if the fracture is from above downward and forward, so that the lower fragment presents toward the ulna, you cannot keep it in place without operation. It is the direction of the obliquity of the fracture that determines the difficulty or ease with which you can treat the fracture.

It has been my misfortune to have three fractures of the radius in a short time, in two of which I have had much difficulty. In one the result was

good and the treatment easy. In another case, in which the patient refused operation, he has about one-third of the rotation of the arm.

DR. A. F. HOUSE

*Dermoid Cyst of Ovary and Other Specimens*

I have here a dermoid cyst of the right ovary, removed a week ago yesterday morning at Tiffin, Ohio. The patient, a woman, 68 years of age, had been in bed five weeks with peritonitis when I saw her. At one o'clock in the morning her temperature was 100 degrees and pulse 96. I rather discouraged operation but the patient insisted on it. The next morning we operated. On making the incision I found a mass spread over the tumor, which at first was quite a puzzle to me. Enlarging the abdominal incision I found it was the spleen. Its upper margin was between the ninth and eleventh ribs. The parietal peritoneum was adherent to the spleen, and the spleen to the tumor. On the left the wall was formed of the broad ligament and small intestine; on the right by the head of the colon, the appendix and a portion of the broad ligament. The tumor had to be entirely enucleated. Here is the wig of hair that was inside the tumor. I am informed by the attending physician that the woman's highest temperature was 99½ degrees. She is now in her ninth day; her temperature and pulse are normal and her appetite good; her bowels moved on Sunday spontaneously, without a laxative.

I have here a specimen which to me is rather interesting. It seems to be a cysto-sarcoma of the right ovary. The left ovary is also shown.

I have here a vesical calculus that I removed two weeks ago last Monday from a boy seven years old. He was three years old before he was able to walk, and from that time on has suffered more or less. He is now running around the ward.

DR. W. H. HUMISTON

*Photograph of a Section of a Fetal Hand*

I am indebted to Dr. Sabin, of Warren, a non-resident member of this society, for a beautiful photograph of a section of the hand of a fetus eight weeks old. It shows the structures very clearly. It is a beautiful specimen.

DR. R. M. WOODWARD

*A Diseased Appendix*

I do not care to say anything. Here is a specimen I will pass around which may be of interest to the gentlemen. It is simply an appendix which illustrates very beautifully the fact that appendicitis does occur. The point of perforation is very plain to everyone. I brought it tonight in the expectation that my distinguished friend, Dr. Hamann, would talk about it. But he has modestly declined. The boy is making a good recovery.

**Program**

DR. M. ROSENWASSER

*A Practical Consideration of Gonorrhea in Women*

This paper appears on page 253 of this number of THE JOURNAL.

WM. THOS. CORLETT, M. D.

*Specific Urethritis in the Male* (Abstract)

Beginning in September, 1893, all cases of gonorrhea seen in dispensary and hospital practice were subjected to local antiseptic treatment. This consisted of flushing the genitourinary tract with a solution of mercuric bichlorid, which varied in strength from 1-50,000 to 1-20,000, the average being 1-30,000. The average duration of the disease was six weeks, complications 60 percent, of which posterior urethritis contributed the most largely. In this series the treatment was begun during the first week of the disease.

In another series of fifteen cases a solution of silver nitrate was used in the same way, 1-25,000. In this series the duration was somewhat longer, being six and three-tenths weeks, although the complications were but 58 percent, of which posterior urethritis was also most frequently met with.

The following year (1894) efforts to destroy the gonococcus *in situ* by direct applications were discontinued, or modified as follows: During the first week, in some cases during the first fortnight, the treatment consisted in regulating the diet to easily digestible articles, such as milk, bread, soft boiled eggs, etc. During the day three pints of hot water were taken in divided doses one hour before meals. Bodily exercise was restricted as much as possible, and if much pain or smarting was complained of the infusion of triticum repens, or tablets of salol and boric acid, containing five grains each, were given four times a day. No local treatment was employed.

As soon as the inflammation began to subside, which usually took place during the first fortnight, creosote in capsules of from one to two minims after meals, or a modified Lafayette mixture was given.

R<sub>x</sub>. Creosote, gtts. xij,  
 Bals. copaibæ,  
 Spts. nitrici dulcis, ää. 3j,  
 Liq. potass. 3ij,  
 Ext. glycyrrhizæ, 3ss.  
 (misce et adde)  
 Ol. gaultheriæ, gtts. xvj,  
 Syr. acaciæ, 3vj. Sig. 3iv. t. i. d.

As soon as the disease began to subside, as evidenced by the discharge becoming pale and watery, and provided no complications were present, local applications were made. For this a rubber syringe holding from one to two ounces, and having a smooth, conical point, was used. The meatus was grasped firmly about the nozzle, thus distending the folds and pockets of the urethra, and the solution retained several minutes. This was employed at first only at night, but after a few days it was used also in the morning. Care was taken to direct the patient to urinate before using the injection. The potassium permanganate (gr. to 3x) gave the most satisfactory results.

The treatment of chronic specific urethritis is of more practical moment, and withal one of the most difficult affections of the urinary tract to eradicate, so that the saying so often repeated by Ricord, "*Une chaude pisse commence, Dieu le sait quand elle finira,*" holds true in many cases today.

First, it is necessary to locate the disease, *i. e.*, whether in the anterior or posterior urethra. This is done by the beaker-glass test, or by the endo-

scope. Anterior urethritis, when diffused, is best treated by forcible distension as previously described, or with a fountain syringe. When limited to small areas direct application through the endoscope should be made. Of the drugs used the permanganate of potassium, from a thirtieth to a quarter grain to the ounce, has given excellent results. Quite recently the preparation Argonin has been employed. This is a silver-proteid compound formed by the combination of casein of milk and silver, producing a whitish powder soluble in water, but not precipitated by sodium chlorid or albuminous fluids. My experience with the drug in the treatment of anterior urethritis after the acute stage has subsided augurs well for its success, although as yet sufficient data have not been collected to speak authoritatively on the subject.

In posterior urethritis the main difficulty has been in making direct applications beyond the *constrictor urethrae* muscle. This has been most satisfactorily accomplished by means of a fountain syringe, which is allowed to exert pressure on the constrictor muscle until it relaxes, thus allowing the fluid to pass into the posterior urethra and bladder. From one-half to one grain of the potassium permanganate to the pint of warm water (100 deg. Fah.) may be used once daily.

#### Discussion of Dr. Rosenwasser's and Dr. Corlett's Papers

DR. W. H. HUMISTON: I regard Dr. Rosenwasser's paper as of great importance to the general practitioner. The gynecologist sees a great many cases of diseased pelvic structures which arise as a result of neglected early treatment of gonorrhea. There is no question as to the frequency of gonorrhea as a cause of serious gynecologic disease. If these cases are *recognized early* and proper treatment instituted the trouble may be limited to the vagina and cervical canal. Pelvic peritonitis with the resulting complications will be avoided and radical operations will be unnecessary. I have a routine treatment where these cases are seen early, and where the disease is limited to the vagina and cervix. Confine patient in bed, wash thoroughly the vulva and vagina with green soap, followed with 1-1,000 bichlorid solution. Dry the surfaces completely with absorbent cotton, and make an application of nitrate of silver 5 or 10 percent solution, applying it freely, coating the mucous surfaces thoroughly, dry the vagina and pack it full of iodoform gauze. This keeps the diseased surfaces apart and takes up the secretions. Allow this to remain in place for 48 hours. In the meantime the general condition of the patient should be attended to—keep the bowels moving regularly, order a bland diet, give water freely, at least a pint an hour before meals and upon retiring, together with some mild alkaline medication. After 48 hours the packing is removed, the vagina is recleansed, and if the cervix is not involved it is let alone. If involved, it should be carefully cleansed with the alkaline solution and bichlorid—nitrate of silver is then applied, and iodoform gauze packed in the cervical canal. After four treatments you will find that the disease has nearly run its course, and by continuing a boric acid douche twice daily a cure will be effected.

In cases that are seen later, with active endometritis, a thorough cur-  
etting and gauze drainage are indicated. Be careful of active instrumental manipulations, as for instance, the use of the sound to determine the size, position and sensitiveness of the uterus. You may be the cause of conveyng

the gonococci to the uterine cavity. I believe the sound is a needless instrument—the size and position of the uterus can best be determined by a bimanual examination.

DR. A. F. HOUSE: There is one method which I have been using for the last two years, that is to dilate the vagina to its fullest extent and inject permanganate of potash. I begin with 1-500. I have had the very best results. Introduce a Furgeson speculum to the cervix and wipe the parts dry with cotton and fill the speculum. As you withdraw the speculum allow the vagina to force out the solution.

DR. O. B. CAMPBELL: The general practitioner is puzzled a good deal to diagnose these cases. He finds evidences of peritonitis and wonders what to do. Generally, in my observation, it is better to do as Dr. Rosenwasser has suggested, not to do anything as to special treatment, but use general remedies only. Perhaps after the discharge commences in the uterus, the vagina should be washed out; at the same time the bowels should be kept open. Later on, perhaps, after two or three weeks the uterus may be carefully washed out with a bichlorid solution. I have done that several times with excellent results.

DR. L. B. TUCKERMAN: I think it is very timely that this paper is read now when all the specialists are advertising that gonorrhea can be cured in three weeks. The fact is that it is becoming very doubtful whether in some cases it is ever cured. I, myself, have cases that have been a year without discharge, in which, by taking a sterile platinum wire and scraping the membrane of the urethra, we find the epithelium still charged, not with any great number of gonococci, but plenty for seed; and the importance of the doctor's paper in emphasizing the uncertainty of the curability of that disease is, to me, very great. So far as diagnosis is concerned, it does not need as high a power to diagnose the gonococcus of Neisser as it does to diagnose the bacillus of tuberculosis.

DR. L. W. CHILDS: In the *American Journal of Medical Sciences*, the bacteriologist of the Boston City Hospital reports successful culture of the gonococcus. The culture medium consists of a mixture of sterilized blood-serum, agar and human urine. In order to grow the gonococcus the medium must be acid. I wish to ask whether the growth of the gonococcus can be clinically arrested by simple alkaline injection.

DR. R. M. WOODWARD: If it may be pardoned, after hearing these two excellent papers, I would like to ask the opinion of the essayists upon the treatment of that exasperating complication, gonorrheal rheumatism. I find it is the bug-bear of my existence, and I believe a good many cases of so-called chronic rheumatism are due to gonorrhea, perhaps latent. I have been unfortunate, perhaps, in the last two years, in seeing a number of these cases. There is one man in the hospital who has been there since August last year. He has had migrating rheumatism which has appeared in all the large joints of the body, and, not satisfied with one tour of his body, when it gets around once, it starts again.

I wish to thank a great many of the gentlemen present for suggestions that have been made in this case and some of them have done considerable good, but the man is still under treatment and liable to stay there for some time.



In regard to the diagnosis you will get as a rule from a man coming to you for rheumatism of gonorrheal origin a history of the gonorrhea about one month before he appears. The attack is of a subacute nature. It is not like migrating rheumatism at all. The temperature is about  $99\frac{1}{2}$  degrees at night and perhaps 98 4-5 degrees in the morning, and runs along week after week in the same way. The joint is not very painful. It is filled with fluid. There is little or no involvement of the heart.

DR. W. E. WIRT: I have introduced a new treatment in joint inflammations which I think might be useful in cases of gonorrheal rheumatism. It is the use of high temperatures. A copper cylinder is closed at each end by a rubber bag or circular covering. The heat is applied by gas or a little lamp, and I have been able to raise the temperature to 290 degrees. A very perfect circulation must be maintained through the cylinder, strong enough to put out a match. There is profuse perspiration of the joint and immediate relief follows in cases of rheumatoid arthritis and in cases where I have suspected gonorrheal rheumatism. In rheumatoid arthritis one is often in a quandary what to do. Passive motion is used and the joint gets worse, or if it is left fixed for a while it gets worse.

I would advise Dr. Woodward to try high temperatures, say 250 degrees to 300 degrees as I have given in my cases with immediate relief lasting for some time.

DR. CRILE: I find gonorrheal rheumatism a most difficult affection to treat. I think, upon the whole, the treatment that has been more satisfactory than any other has been the use of the thermo-cautery, fixed dressings, preferably plaster of paris, and the administration of salol.

DR. M. ROSENWASSER: I would again lay stress upon the subject of recurrence of gonorrhea as a cause of chronic infection. The experiments upon which the information I have given is based are these:

A man had been suffering from chronic gonorrhea for two years; a sample of the discharge was taken and a pure culture made of it. The pure culture was first injected into the urethra of the same man and produced no effect. Another sample of the same culture was injected into the urethra of a paralytic, not expected to live, and it immediately set up an acute urethritis. A pure culture was then made from the discharge of the paralytic and the original giver was submitted to infection from this culture, and he at once received a fresh dose of urethritis, showing that the germ was not dead or latent, but that the medium had been exhausted. You see now why a chronic condition of urethritis, or vaginitis is not easily cured. Now then how are you going to cure it? In the treatment of man and wife, you must keep them from cohabiting until cured, which you can tell best by the culture-test. The culture-test is a much more delicate test than that by the microscope. The microscope is not accurate enough. Wertheim has shown that the culture-test will demonstrate the gonococcus where the microscope has failed to show it. If one is cured and the other not, and they cohabit, you have reinfection. In order to prevent the occurrence of the trouble you must therefore separate husband and wife for a long period of time.

That also answers the question Dr. Tuckerman put: Is gonorrhea curable at all? If you can keep the diseased organs absolutely at rest, and keep the sexes apart there will be a final cure. The disease is self-limited.

I cannot say that the abortive treatment meets with my approval. It may mitigate the disease in some cases, but will aggravate it in more. In no case is a cure effected in the time specified, ten days. As to the question of Dr. Childs, it is still undecided whether the germ flourishes better in acid or alkaline media. The secretions of the vagina are acid, yet after the vagina is once infected the germ will flourish there very nicely. So it will in the cervical canal, where the secretions are alkaline in reaction.

The question of best treatment of gonorrheal rheumatism I cannot answer myself. I have had only a few cases. One applied a few weeks ago. She is not well. She has been treated in various ways without relief. I believe that if the gonococcus is really averse to any disturbance, long rest would be the best treatment, unless Dr. Wirt's treatment prove to be better.

In the peritoneum pure gonococcus culture will cause not a pus, but a fibrinous exudate, and rapid formation of adhesions. It is these adhesions that close up the tubes. May not similar adhesions form in and about joints, thus causing incurable conditions? I do not wish to be understood as an authority on the matter; I am only theorizing.

**DR. CORLETT:** About the only thing left for me, it seems, is to tell how to treat gonorrheal rheumatism. I have unfortunately seen a good many cases of gonorrheal rheumatism. The most unfortunate of all is one I will speak of, because it brings out certain points raised by Dr. Woodward, and because it illustrates the futility of therapeutic measures in certain cases. A young man who had never before been infected contracted gonorrhea. A few days after the disease appeared he developed a high fever, 103 degrees, his ankle became painful, he was placed in bed, given a milk diet and sodium salicylate administered. In a few days it shifted to the knee where it remained, although other joints were from time to time affected. During the six months he was confined to bed the various methods of treatment in vogue, both internal and external, were used, but without avail. He finally recovered with a stiff joint. The urethritis subsided without special treatment in about ten days. If Dr. Woodward will allow me to differ from him, I think in some cases it goes to the pericardium in common with the synovial membranes.

In regard to aborting gonorrhea, I quite agree that the abortive treatment is a delusion and a snare, and I have never found anything but ill results following its use.

#### REGULAR MEETING, MAY 8TH, 1896

*The President, DR. COOK, in the chair*

#### Reports of Committees

**DR. HUMISTON,** of the committee appointed by the President to report upon the death of Dr. Scott, submitted a report.

**THE PRESIDENT:** The loss of Dr. Scott is a loss to the profession of this city, and the profession has deemed it proper to hold a memorial service. It has been arranged that that service will be held next Monday evening in the rooms of the Builders' Exchange, under the auspices of the three medical societies, the Cuyahoga County, the Medico-Legal and the Cleveland Medical.

## Report of Cases and Exhibition of Specimens

DR. C. W. HOLLIS

of Chippewa Lake, by special permission, showed a case of

*Ankylosis of the Shoulder-Joint*

DR. W. E. WIRT: This case is somewhat interesting to me. The first injury to the shoulder was due to throwing a ball, and the patient was then unable to use the arm for a week or ten days. After that there was, from time to time, pain in the shoulder and an increasing loss of power. This state of things continued for about three years. He then fell in wrestling and struck the shoulder. At that time he was laid up for about two weeks and was unable to use the joint. He recovered the use of the arm and was able to raise it above his head, but had some pain. Loss of power became more and more marked with gradual atrophy, until in the past year he has used it very little. We cannot imagine that from the effort of throwing the ball the shoulder was dislocated. The parts now appear in their normal relation. This gradual loss of power and atrophy correspond to an inflammation in the joint. I have seen a number of cases quite similar to this that have gone under the name of *arthritis sicca* or dry arthritis. That is what I think the trouble is. Resection is done with considerable satisfaction in these cases, and gives great increase in the usefulness of the arm. That is what I would advise in this case.

## Program

DR. H. W. ROGERS

*Some Common Affections of the Heart and their Treatment*

This paper appears in full on page 262 of this number of THE JOURNAL

DR. C. F. HOOVER: Dr. Rogers has spoken of the very marked subjective signs in persons who have only very little of an objective nature that is demonstrable in their vascular system. There is one point in the study of patients with arterial sclerosis I wish to call attention to, *viz.*, regional arterial sclerosis. Recently I saw an autopsy on a man who died from cerebral hemorrhage, in whom the arterial sclerosis was very marked in the cerebral and renal arteries only, the other regions of the aortic distribution being relatively free from sclerosis. I have seen very advanced atheroma with beaded walls of one radial artery and only slight thickening in the other radial of the same man. Recently a man came to the polyclinic complaining of pain in the right side of the head and neck. By inspection one could see that sclerosis was much more marked in the right carotid than in the left. The pulse of the right carotid had an interruption high in the katacrotus (first  $\frac{1}{4}$ ) showing greater peripheral resistance to the right carotid than the left. Another interesting thing in the same man was marked *arcus senilis* in the right eye and only a slight degree of *arcus senilis* in the left eye. So one could truthfully say the man was senile on the right side of his head and middle-aged on the left side. Another patient complained of severe headache which lasted day and night. Of his own account he said he was very pale when the headache was particularly bad. The radial artery had thickened walls, but a pulse of moderate volume and rather of

the *pulsus celer* than *tardus* type. The same was true of the femoral arteries. To my surprise the aortic second was considerably accentuated and the carotid pulses were both of high tension and long duration with a marked predicrotic interruption (first  $\frac{1}{4}$  of the katarotus) that was distinctly visible and palpable. The ophthalmoscopic examination showed marked tortuosity of the retinal arteries. With nitroglycerin 1-100 four times daily the headaches disappeared entirely and the predicrotic interruption in the carotids also disappeared. I saw the man two weeks after he had ceased the use of nitroglycerin and there had been no return of the headache. The alteration in the character of the carotid pulse was also permanent. The man was suffering from cerebral anemia due to sclerosis in the small arteries of the carotid distribution. Another man I saw recently had severe pain in the right hand that could not be accounted for by any involvement of the soft or hard parts or nerve-supply of the hand. There was the same mottled appearance of the back of the hand due to teleangiectasis that we see in beginning senile gangrene. There was marked arterial sclerosis with predicrotic interruption in the carotids and brachials. Nitroglycerin completely relieved the pain and changed the character of the pulse.

DR. J. T. SMITH (of Collinwood): I had a case of typhoid-fever in which there were frequent attacks of angina pectoris *sine dolore*, which were promptly relieved by the use of morphin given hypodermically. I kept the patient steadily on strychnin and digitalis. When attacks of angina pectoris came on I administered morphin.

DR. J. G. SPENZER: The several members of the amyl nitrite group owe their physiologic action to the nitrous acid already present as a nitrite or subsequently formed by the reduction of a nitrate in the blood. The rapidity of action is due to the ease with which the several compounds of this group give up the acid radical; thus amyl and ethyl nitrites, if inhaled, produce almost immediate effects; the nitrites of the alkali metals have the same properties, and therapeutically have the same indications. Nitroglycerin (glycerol trinitrate) is slower and more lasting in its action, because of the necessary and gradual reduction to nitrite, which it must undergo in the blood, since nitrates do not influence the central origin of the peripheral nerve filaments supplying the smaller blood-vessels and to which the physiologic effects of nitrous acid are ascribed.

DR. ORWIG: It seems to me that it cannot be a fact that functional disorders of the heart, which are so common, are always an indication of something more serious, as I understood Dr. Rogers to say. I have in mind this evening a man whom I examined for life insurance seventeen or eighteen years ago. He then had a pulse of 40 or 42. Of course, he was not accepted. That man has been very active in business from that time to the present. As far as I know his health is as good now as any man's could be. I see him frequently at his business. I do not think he had anything more than functional disorder. There are a great many cases of functional derangement of the heart in women who have some uterine trouble. These cases will sometimes run along for years and then get better. The great question is what to do with them. We can, by the use of heart stimulants, and sometimes nerve sedatives, carry them along for a time and make them comfortable, but when we discontinue the remedies the heart trouble returns.

DR. P. H. SAWYER: The physician should be alert early and do what he can to prevent such troubles. With a little careful attention the conditions of blood-pressure, and of arteries and capillaries can be determined; and whether there are any of these minute changes going on, and if so, ascertain their cause and correct the condition. For instance, if we find that our patient is dyspeptic, we should seek to know just why that comes about, and to modify it so as to avoid those changes which are continually going on.

DR. O. B. CAMPBELL: I am not prepared either by recent clinical experience or reading to discuss Dr. Roger's able paper, but I have a case that bears in some respects on heart trouble. A little boy about nine years old had pneumonia; after the initiatory chill, his temperature was very high, about 106, and his pulse 140 to 145. Under the ordinary treatment he got better, but there was a distinct crisis, the pulse dropped to 40 and the temperature fell three degrees below normal. I have been unable since deferescence with any of the heart stimulants to get the pulse above 55. During this time there has been a great deal of congestion of the liver. How long he can continue in that way or whether he will continue to improve, as he is evidently doing, I am not able to say. I saw him today with a pulse of 44.

DR. ROGERS: I do not know that I have anything special to add to what has already been written. I would say in reply to Dr. Campbell that sometimes acute diseases occasion changes of the heart-muscle that have to be looked after and require some other treatment. The heart requires reconstruction. I am firmly of the belief that often serious organic lesion of the heart receives its inception during attacks of acute specific disease; and it is very wonderful to notice in chronic endocarditis the various forms of germs that are found upon the surface of the heart valves, some of them characteristic of various forms of specific disease.

DR. W. H. HUMISTON

*Topics of Interest in Gynecology*

[This paper will be published later]

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## Book-Reviews

DIAGNOSIS AND TREATMENT OF DISEASES OF THE RECTUM, ANUS AND CONTIGUOUS TEXTURES: Designed for Practitioners and Students, By S. G. Gant, M. D., Professor of Diseases of the Rectum and Anus, University and Women's Medical Colleges; Rectal and Anal Surgeon to All-Saints German, Scarritt's Hospital for Women, and Kansas City, Fort Scott and Memphis Railroad Hospitals, to East-Side Free Dispensary, and to Children's and Orphan's Home, Kansas City, Mo.; with two chapters on "Cancer" and "Colotomy," by Herbert William Allingham, F. R. C. S., Eng., Surgeon to the Great Northern Hospital, London. One Volume, Royal Octavo, 400 pages. Illustrated with 16 full page Chromo-Lithographic Plates and 115 Wood Engravings in the text. Extra Cloth, \$3.50 net; Half Russia, Gilt Top, \$4.50 net. The F. A. Davis Company, Publishers, 1914 and 1916 Cherry Street, Philadelphia; 117 W. Forty-second Street, New York; 9 Lakeside Building, Chicago.

This is an octavo volume, on good paper and large type. It is a treatise upon the diseases of the rectum and anus, and contains in addition to a general consideration of these subjects, a series of cases of different sorts, setting forth the work done by the author. The illustrations are one hundred and fifteen in number, and among them is a series of colored plates which are very well produced. Some of the illustrations are well chosen. It would seem, however, almost needless to picture a Kelley's pad, an Esmarck inhaler and a Paquelin cautery. While some of the subjects are treated with clearness, the descriptions given of surgical procedures are scarcely sufficiently detailed for those not accustomed to operate, and are too elementary for those experienced in surgery.

On page 33 the author speaks of the treatment of congenital fecal fistula terminating in the vagina as being comparatively simple. His method of operating is by an incision backwards and the drawing of the rectum downward and backward and suturing it to the integument. The operation is scarcely as easy as it would seem from his description.

On page 53 is a picture of a dwarf child, who has suffered from extensive prolapse of the rectum. Inasmuch as the picture is of the child standing entirely clothed, and in front view, it is questionable how much value it adds to the text.

On page 69, in speaking of ischiorectal abscess, the author says that one should first "ferret out the cause and correct it, then endeavor to reduce inflammation by applications of cold, rest in bed, and the use of mild laxatives." It would be better instead of advising palliative measures to insist more strongly on the great advantage to be gained by an operation as early as possible.

On page 81, in speaking of the internal opening of fistulas, he says, "Frequently the opening will be found just between the internal and external sphincter. It is not uncommon, however, to find it much higher up." It would be well in this connection to insist upon the vastly greater frequency with which the opening is low down and the importance of finding this with a probe, and the avoidance of making a false opening without finding the true opening.

Chapter XXV treats of the subject of auto-infection from the intestinal canal, and contains letters from Dr. Roswell Park and Dr. Wm. H. Welch. While these are interesting, it seems difficult to understand the exact relationship which this subject bears to diseases of the rectum.

There are two chapters by Mr. Herbert Wm. Allingham, of London. One is upon the subject of cancer of the rectum, and the other upon colotomy. These doubtless add to the interest of the book.

The final chapter is upon railroading as an etiologic factor in rectal diseases. What the importance of this occupation may be in producing hemorrhoids as compared with others, would necessarily require wider statistics. The suggestion, however, is an interesting one.

Regarding the book as a whole it may be said that it presents points of interest, and gives evidence of a considerable amount of labor. In a later edition, however, it could be greatly improved.

D. P. A.

## Medical News

**Dr. W. J. Gillette**, of Toledo, was in the city April 30, the guest of Dr. W. H. Humiston.

**Dr. Thomas Hubbard**, of Toledo, visited professional friends in the city Tuesday, May 19.

**Dr. H. S. Straight** attended the meeting of the Tri-County Society at Ashtabula, May 5.

**Dr. Harold T. Clapp** has been quite sick with acute inflammation of the middle ear, following grip.

**Dr. A. F. House**, Dr. W. C. Weber and Dr. A. R. Baker attended the Atlanta meeting of the American Medical Association.

**Dr. H. C. Long**, of this city, was married April 28 to Miss Minnie Lindsley, of Sandusky, a daughter of the late General Lindsley.

**Drs. J. H. Lowman** and H. S. Straight attended the meeting of the American Laryngological Society at Pittsburg, May 13 to 16.

**Dr. Charles F. Hoover** has been elected Professor of Physical Diagnosis in the Medical Department of Western Reserve University.

**Dr. W. F. McLean**, of Elyria, and his brother, Dr. James W. McLean, of Fayette, Iowa, were in the city May 18, calling on medical friends.

**Dr. Edward F. Cushing** has been elected Professor of Diseases of Children in the Medical Department of Western Reserve University.

**Dr. William H. Humiston** has been elected Associate Professor of Gynecology in the Medical Department of Western Reserve University.

**Dr. and Mrs. C. B. Parker** gave a reception to the trustees and faculty of the Ohio Wesleyan University, May 19, at their residence, 425 Euclid Avenue.

**Dr. and Mrs. H. R. Handerson** gave a large reception at their home, 444 Dunham Avenue, May 13, at which many physicians of the city were present.

**Dr. Paul Opperman** left for Mexico May 1st, expecting to be gone two or three years. He has accepted a position as surgeon to a silver mining company.

**An esteemed** homeopathic contemporary recently published an editorial upon "Homeopathy Tempered with Good-Sense." The title is certainly suggestive.

**Lorain** is to have a \$30,000 filter for its water-works, which will be constructed under a guarantee that it will remove 97 per cent. of the bacteria of the lake water.

**Dr. M. J. Love**, of Bloomingville, was a visitor in the city May 18.

**Dr. T. M. Sabin**, of Warren, was in Cleveland May 20.

**Dr. F. D. Case**, of Ashtabula, visited professional friends in Cleveland May 22.

**Dr. E. G. Carpenter** has returned from his long stay in Europe, where he has been doing special work in neurology. His present address is the Hollenden Hotel.

**Dr. John G. Spenzer** has been elected Professor of Chemistry in the Cleveland College of Physicians and Surgeons—Medical Department of Ohio Wesleyan University.

**Dr. C. A. Hamann** attended the meeting of the American Association of Medical Colleges at Chattanooga May 4, and the meetings of the American Medical Association at Atlanta the following days.

A large party for Atlanta left Cleveland Sunday morning, May 3, in a special car over the "Big Four" railroad. There were physicians and their wives from Cleveland, Erie, Buffalo, Canton, and other places.

**Dr. W. H. Humiston** has been appointed, by Mayor McKisson, a member of the citizens' advisory commission to cooperate with the administration in the construction of the garbage plant and flushing tunnel.

**The Buffalo Medical Journal** announces that its June issue will be written, edited and published exclusively by women. This, we believe, is the first instance of the issuing of a women's edition of a medical journal.

**The Cleveland Medical Society Outlawed.**—The judicial council reported that no members of the Cleveland Medical Society should be admitted to membership in the association as delegates from that or any other society.  
—*Medical Record*

**Dr. W. H. Humiston**, by invitation, addressed the Tri-County Society at Ashtabula, May 5. This society, composed of the physicians of Lake, Geauga and Ashtabula counties, always has very interesting and profitable meetings.

**At the annual meeting** of the Buffalo Microscopical Club May 18, the president, Dr. Frank J. Thornbury, gave an address entitled "A Tribute to Pasteur," in which he reviewed the salient features of the scientific career of the great bacteriologist.

**Governor Bushnell**, on April 28, appointed the medical staff of the State Penitentiary at Columbus. Dr. F. S. Wagenhals, of Columbus, was named as chief physician, with Dr. C. A. Thorp, of Columbus, and Dr. H. R. Parker, of Cleveland, as assistants.

**The Virginia Medical Semi-Monthly** made its initial appearance April 10, 1896, with its form and dress quite changed from its predecessor—the monthly of the same name. The *Semi-Monthly* is to be congratulated upon this evidence of prosperity.



**Announcement** is made of the marriage of Dr. Frank S. Clark, of this city, to Elizabeth, daughter of Mr. and Mrs. Andrew J. Marvin, on Thursday, May 21.

**On the night** of April 24 the house of Dr. F. E. Bunts, at 116 Clinton Street, was thoroughly ransacked by burglars. Until the doctor's return from Europe the exact loss will not be known as the house had been closed during the absence of the family.

**The Ohio State Board** of Medical Registration and Examination, on May 4, announced that Section 4,403 of the Kimmell Law would be given special consideration May 26, at 8 P. M. This was to decide the controversy between the oculists and opticians.

**Vol. I, No. 1,** of *Weir's Index to the Medical Press*, came to hand early in May, and it is a very creditable publication. The titles of papers are classified by subjects, and a list of new books is added. The work of preparing and printing the *Index* has been well and carefully done.

**The N. Y. Medical Journal** of April 25 contains a double page half-tone engraving of a Röntgen picture of a fetus, taken by Dr. W. J. Morton. It is the most remarkable picture yet published. The stage of development of the bones is easily made out and even coils of intestine are plainly visible.

**The Surgeon** of the Marine Hospital Service at Gallipolis, who was tried for criminal abortion and acquitted, as noted in our May issue, is not an officer of the Service, but an "Acting Assistant Surgeon," that is a local physician in general practice who is transiently employed to treat the Service patients who appear at that point.

**Water Supply** of the Lake Cities:—The *Indiana Medical Journal* says that Buffalo, with an abundance of pure water within easy reach, is short of pure water, and, like Chicago, is in the condition of the ox that drinks and passes water in the same pool. Duluth is another lake city which has suffered severely from self-pollution of its water-supply. There is no excuse for any lake city being short of water or drinking its own sewage.

**Mr. H. R. Simon**, of this city, a member of the graduating class of the Medical Department of Western Reserve University, was, upon May 20, the day of his graduation, badly injured by a runaway horse attached to a heavy wagon. The runaway came upon the sidewalk where Mr. Simon was walking, and he was dragged between the wagon wheels and the iron fence surrounding St. John's Cathedral at the corner of Erie and Superior streets. He received very severe injuries.

**Dr. L. B. Tuckerman** has spent some time in Washington as the representative of the Cleveland Chamber of Commerce, urging the passage of Mr. Burton's bill to increase the powers of the Marine Hospital Service by making permanent the temporary regulations for the inspection of immigrants which were in force during the European epidemic. He appeared before both the Senate and House committees having the matter in charge and made strong arguments in favor of the measure.

**The General Practitioner** of St. Louis says that "one of the most prominent physicians and surgeons of Cleveland was recently convicted of murder," and further says: "The verdict of guilty caused a great sensation in medical circles." Our contemporary is kindly informed that "the most prominent physicians" of Cleveland do not engage in criminal abortions and that the verdict caused no sensation whatever. We regret that our contemporary was not in possession of the facts in the case before it spoke.

**Dr. Asa Brayton**, of Carey, Ohio, has recently been sued for \$3,000 damages. The petition states that the plaintiff was ill and required the use of hot applications to her body, and her sufferings were so intense that the defendant, as her physician, deemed it advisable to use anesthetic remedies and narcotics, so that the plaintiff became unconscious, and while in such condition defendant caused hot plates and irons to be placed upon and about her, heated so hot that they burned her feet to a crisp, leaving wounds and sores from which she has never recovered.

Where was the nurse all this time? If none was at hand, would it not have paid the family to have secured the services of a good nurse, if the above allegations are true?—*Columbus Medical Journal*.

### The Medical College of Western Reserve University

The commencement exercises of this school were held on Wednesday, May 20th. The usual Alumni meeting in the afternoon was very successful in every way. The commencement itself was held in the evening at the Y. M. C. A. Hall, and Pres. Wm. Peirce, of Kenyon College, gave the address. His subject was "Idealism and Materialism." He showed himself a thorough master of psychologic science as affected by discoveries in physiology and brain localization, and especially by the writings of Lombroso and his school. The audience was large and appreciative. Diplomas were given to the following class of 27 members: Frank Acker, George J. Ashby, Louis P. H. Bahrenburg, Homer C. Ballard, Frank P. Charvat, George R. French, Jacob Fridline, George F. Garmier, Harry L. Gilchrist, N. Atwood Haning, Charles J. Harris, William Hendry, George T. Holmden, Aaron P. Howland, William G. Huffman, James F. Kelley, C. Edward Kimmerline, Walter B. Laffer, Thomas Linley, William P. Love, A. B., Henry R. Morse, Louis Theodore Schurrer, Henry R. Simon, Torald Sollmann, Charles H. Tanner, A. B., Samuel J. Webster, Edward W. Wellman. An address by the Dean, Dr. Hunter H. Powell, followed. After the conclusion of the exercises a banquet to the Alumni and graduating class was given at the Stillman. It was well attended and thoroughly enjoyed by those present. The following toasts were responded to: "Our Professional Brethren," Dr. M. Rosenwasser, Dean of the Cleveland College of Physicians and Surgeons; "The Medical School," Dr. G. N. Stewart; "The University," Professor Mattoon M. Curtis; "The Alumni," Dr. C. M. Plummer; "The Class," Dr. G. T. Ashby; "The Kinship of the Professions," Mr. Francis J. Wing. Dr. R. M. Woodward presided as toastmaster and introduced the speakers in his usual felicitous manner. It is a notable fact that Dr. Plummer, who responded to the toast, "The Alumni," was a member of the class at the opening of the school in 1843.

## Condensed Table of Mortality in Cleveland for April 1896

*By courtesy of Dr. J. L. Hess, Health Officer*

<b>I—ZYMOTIC DISEASES</b>					
Measles .....	0	Asthma.....	1		
Scarlet Fever.....	1	Congestion of brain and men-			
Diphtheria .....	11	inges.....	23		
Croup.....	4	Apoplexy.....	11		
Whooping cough.....	5	Paralysis.....	15		
Typhoid-fever.....	15	Epilepsy .....	0		
Cholera, cholera morbus and		Tetanus.....	0		
cholera infantum.....	8	Convulsions.....	49		
Acute diarrhea.....	1	Other diseases of brain and cord	5		
Chronic diarrhea .....	0	Diseases of heart.....	21		
Dysentery.....	1	Aneurism.....	0		
Cerebrospinal meningitis.....	0	Abscess .....	0		
Erysipelas.....	2	Dropsy.....	8		
Malarial fever.....	4	Diabetes .....	4		
Syphilis.....	1	Bright's disease .....	7		
Pyemia and septicemia.....	6	Peritonitis, gastritis and perfor-			
Alcoholism.....	0	ation.....	16		
Inanition.....	12	Hernia and obstruction of intes-			
	71	tines.....	3		
		Diseases of liver.....	3		
<b>II—CONSTITUTIONAL DISEASES</b>		Genitourinary diseases.....	0		
Cancer .....	24	Hip disease.....	0		
Rheumatism and gout .....	3				232
Marasmus, scrofula and <i>tubercu-</i>					
<i>mesenterica</i> .....	15	<b>IV—DEVELOPMENTAL DISEASES</b>			
Hydrocephalus and tubercular		Puerperal diseases not septic.....	5		
meningitis .....	0	Infantile debility.....	19		
<i>Phthisis pulmonalis</i> .....	43	Dentition.....	1		
Anemia.....	1	Senectus .....	20		
	86				45
<b>III—LOCAL DISEASES</b>		<b>V—DEATH BY VIOLENCE</b>			
Pneumonia and congestion of		Accidental.....	13		
the lungs.....	53	Homicide .....	0		
Bronchitis, acute.....	6	Suicide.....	5		
Bronchitis, chronic .....	4				18
Tonsillitis.....	1				
Pleurisy.....	2				
Total deaths for April, 452. Total deaths for April, 1895, 457.					
Annual death-rate per 1000 during the month (estimated population 330,279) 16.66+					

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# Cleveland Journal of Medicine

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JULY, 1896

NO. 7

## The Treatment of Croupous Pneumonia

BY J. C. WILSON, M. D.

*Professor of Practice of Medicine and of Clinical Medicine in Jefferson Medical  
College, Philadelphia*

*Gentlemen, Members of the Cleveland Medical Society:*

WHEN your secretary did me the honor to ask me to read a paper before you upon some subject of general interest to practitioners of medicine my mind turned at once to the treatment of croupous pneumonia; when he advised me that the paper would be made the subject of discussion on the part of the Society I was led to hope that the selection had been a fortunate one.

Croupous pneumonia is a common disease. The statistics of general hospitals rank it at about three percent of all admissions. It is fully as frequent among those classes of society whose members are treated at their own homes. It is a disease to which men of our own profession are especially prone, and the sudden prolonged chill, the high fever, the stitch in the side, the oppression, which mark the onset of the attack, only too often constitute the beginning of the end of an active and useful medical career. There is none within the reach of my voice who will not vividly recall the death of one, perhaps several professional friends, from croupous pneumonia, and we all think, as I speak, of the leaders who have been thus cut down. It is a disease of every period of life. The youngest are liable to it, the oldest die of it; it constitutes very frequently the terminal event in all kinds of chronic disease. It attacks alike the debilitated, who may not succumb,

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*Read before the Cleveland Medical Society June 12, 1896*

and the most vigorous, who may not survive. More relentless than most of the other infectious diseases, it not infrequently spares its victims only to renew the attack time after time in the future. It presents a symptomatology which varies within the widest limits, so that the croupous pneumonia of infancy and childhood, of adolescence, of adult life and of old age, the croupous pneumonia of alcoholic subjects, that secondary to antecedent infectious processes or wasting diseases, the forms due to different local lesions, central pneumonias, apex pneumonias, crossed and double pneumonias, migrating pneumonias, present a series of clinical pictures attended by wide variations in symptoms and only to be understood by reference to the key supplied by the local pathologic process. It is a disease with which the general practitioner and medical clinician are only too familiar; but concerning which the surgeon and the specialist cannot disclaim anxiety. Its sudden onset or insidious development may mar the most brilliant operative success.

Croupous pneumonia is furthermore of general interest because we know so little of its etiology. The exciting agent, it is true, is the *micrococcus lanceolatus*, but why this bacterium, which sometimes gives rise to meningitis, often to pneumonia and occasionally to both, and which is apparently very widespread in Nature, should become active with singular suddenness and intensity under the most diverse conditions, remains wholly obscure. Sudden chilling of the body can no longer be regarded as the efficient cause of the attack, since, in more than half the cases, no history of cold can be obtained. In temperate climates the disease is more prevalent during the winter months, but less common during the steady, low temperature of midwinter than during the changeable season of the early spring. Contrary to former belief croupous pneumonia is prevalent in hot climates, and in this country even more common and more severe in the southern States than in the northern.

This disease is of interest also because of its high mortality. General hospital statistics show a death-rate ranging between twenty and forty percent. When we consider the modifications of pneumonia under different circumstances and at different periods of life, from childhood to old age, we are impressed with the uselessness of attempts to show by statistics the value of different plans of treating the disease. No general percentages of mortality can be relied upon as indicating the efficacy of any form of treatment, unless they are upon a large scale and accompanied by a critical analysis of the condition of the patients. It is a question of the seed, which is probably always the same, and the soil, which is indefinitely modified. Hence, methods of treatment at one time credited with surprising results in reducing the mortality of the disease have failed to stand the test of time and have fallen into disuse. The indiscriminate employment of heroic measures is no longer sanctioned. In recent years attempts have been made to show, by

the comparison of later with older statistics, that the mortality from croupous pneumonia has been increasing, and to associate this alleged increase with changes in the method of treatment. It is obvious that errors in the early statistics of this disease must arise in consequence of the fact that prior to the middle of the present century the diagnosis of croupous pneumonia among practitioners at large was by no means exact, some other pathologic processes affecting the chest being included. There are other elements of error in a comparison of the recent and early statistics. Townsend and Coolidge, a few years ago, made a critical analysis of one thousand cases treated in the Massachusetts General Hospital from 1822 to 1889. The average mortality was 25 percent. This gradually increased from 10 percent in the first decade to 28 percent in 1889, but the average age of the patients increased from the first to the last decade. The relative number of delicate and complicated cases also increased, as did the relative number of foreigners. These observers do not regard the treatment, which was heroic before 1850, transitional between 1850 and 1860, and expectant and sustaining since the last date, as having influenced the mortality rate, the duration of the disease or its convalescence. They found that when fatal cases over fifty years of age were excluded, together with feeble and intemperate persons and complicated cases, the variation from decade to decade was but slight, the death-rate in the remaining cases being but little above 10 percent.

At this point we may well direct our attention to the prognosis in individual cases. It is in accordance with general experience that the death-rate increases progressively with the age. An analysis of 708 cases at St. Thomas's Hospital by Hadden, Mackenzie and Ord showed a progressive mortality increasing with each decade of life.

Prior to the 20th year,	293 cases with 11 deaths; 3.7 percent
In the third decade,	153 " 34 " 22 "
In the fourth decade,	120 " 37 " 30.8 "
In the fifth decade,	85 " 32 " 47 "
In the sixth decade,	27 " 15 " 51 "
In the seventh decade,	14 " 9 " 65 "

In truth, croupous pneumonia may be said to be the mode of death for old people. It has been estimated that nine-tenths of all deaths occurring after the eightieth year are due to this disease. Yet there are singular recoveries. I know a lady of 88, bright, clear and remarkably active, who, since her eightieth birthday, has had three well-characterized attacks of croupous pneumonia. Another recovered twice from apparently hopeless attacks after the eightieth year to succumb at 86 to a third attack occurring as a complication of influenza. In many cases the prognosis is hopeless from the outset. Pneumonia is the mode of dying, not only with the aged, but also with many cases of chronic and wasting diseases, such as nephritis, dia-

betes, pulmonary tuberculosis, cancer, pernicious anemia, tabes and other degenerative diseases of the nervous system. On the other hand astonishing recoveries occur. I recently saw, in consultation, a woman, 44 years old, on the sixth day of an attack of croupous pneumonia, presenting the physical signs of an exudate involving the greater part of the right lung and the lower lobe of the left lung, with a pulse varying from 180 to 200 beats per minute, respirations of 60, a temperature of 104 degrees F. and cyanosis. This patient had a clear mind, practically no nervous symptoms, and made a good recovery. Many times have I seen cases in which both lungs have been involved to an extent which seemed incompatible with a continuance of the respiratory function end in recovery. Still more often have I seen cases of pneumonia with a circumscribed exudate scarcely involving the whole of a lobe terminate in death. The other day I saw, with a medical friend, near Philadelphia, a woman aged 28 in a second attack of croupous pneumonia. This time the patient had been pulled down by measles, through which she had passed a few weeks before. There were the signs of a limited involvement of the lower lobe of the right lung, a temperature ranging between 103 degrees and 104 degrees F., pulse 120, urine not albuminous, a good deal of prostration, perfectly clear mind. The case seemed to be pursuing a favorable course until upon the seventh day pulmonary edema suddenly developed and death occurred in a few hours. Death may take place from restriction of the respiratory area, from failure of the right heart, or from the action of toxic principles upon the nervous system, the last being the most common. Hence, we have come to regard great restlessness, delirium and a tendency to stupor as ominous. Hence, also the extreme danger of pneumonia in those broken down by alcoholic excesses; but even in this group of most unfavorable cases amazing recoveries occasionally take place.

He who would venture to attribute these exceptional recoveries to any plan of treatment would display rather confidence in therapeutics than knowledge of the natural history of the disease. If plans of treatment could cure, recoveries from the more serious cases would be common, not exceptional. If plans were curative, they would be few in number and generally accepted; not many and questionable.

Being deprived of the best test of methods of treatment in the acute infectious diseases, namely, the reduction in mortality, we are forced to fall back upon the second test, that is, the influence of treatment upon the course of the disease in individual cases or series of cases, a test so largely influenced by the personal equation of the observer that it is, in a disease like croupous pneumonia, without value in limited collections of cases, and only acquires importance by the concurrent testimony of many clinicians in different fields of practice. No one who has studied the history of medicine dur-

ing the nineteenth century can fail to be impressed with the fact that the trend of opinion in regard to the treatment of croupous pneumonia has been steadily toward an expectant plan. Heroic methods are no longer taught or practiced. The employment of antimonials has passed away. The brilliant advocacy of Trousseau is but an echo of the past, and his favorite *Kermes mineral* is almost forgotten. The indiscriminate venesection of our forefathers—bleeding *coup sur coup*—is no longer spoken of, save in condemnation.

Massive doses of quinin, as recommended by Jurgensen, are no longer used, while the treatment by small so-called tonic doses at short intervals throughout the attack, as has been commonly practiced, appears to be rapidly going out of favor. At one time, following the practice of Bartholow, I was in the habit of administering a single large dose of quinin to the patient when first seen, but I have long abandoned this measure as a matter of routine; first, because I rarely saw the cases early enough to justify it upon theoretic grounds; and secondly, because I was never able to realize any demonstrable benefit from it.

Direct arterial sedatives, aconite and *veratrum viride*, long held sway, and there are yet many practitioners who regard their administration, especially in the early stages, as an essential part of the successful treatment of pneumonia. The number of those who depend upon drugs of this class is, however, rapidly diminishing. To add the depressing effect of a powerful drug to pathologic influences already depressing the circulation is now recognized as increasing the danger of cardiac failure. The practice was originally based upon a false conception of the nature of the pneumonic process, and its advocates at this time are too much influenced by mechanical views relating to the circulation in pneumonia. Since, as we now know, many of the symptoms are due to toxemia, it were better to bleed the patient, if he is to be bled at all, into a basin than into his own vessels. To depress the heart by *veratrum viride* or aconite in the early course of pneumonia, and to harass it by digitalis at a later period are among the vagaries of a therapeutics, which takes pleasure in vaunting itself as rational. To give cardiac depressants in croupous pneumonia is often harmful, and always of doubtful expediency.

Of digitalis, Brunton has said "It is of little use in pneumonia." I find, however, that this drug enters into the routine treatment of many physicians, though usually in insignificant doses. I believe that it should be employed only in response to definite indications. The enormous doses advocated by Petresco are seldom employed in this country. Two drams (8) of the powdered leaves in the course of twenty-four hours, equivalent to about two ounces (30) of our official tincture, administered in the first stage of the disease, will, it is claimed by this observer, abort the attack or hasten the crisis in cases that have already entered upon the second stage. If the claims



made by Petresco, as extravagant as his dosage, had been substantiated, this treatment would have been generally accepted.

Delafield regards as most satisfactory the combined use of aconitin in the dose of one-sixth mgr., and digitalin, one-eighth mgr., together with alcohol, and in this connection is to be mentioned the "Trinity pill," used in St. Luke's Hospital, New York, in which strychnin arseniate, one-half mgr. is associated with the digitalin and aconitin.

Blood-serum therapy as first suggested by the brothers Klemperer, of Berlin, is clearly in the line of the present development of organotherapeutics. Though a series of successful cases has been collected by Shattuck (1893), and cases have been treated by Hughes and Carter and others in this country, the subject must be regarded as in the experimental stage.

The direct injection into the lung of antiseptic solutions has been practiced by Lépine and others. For this purpose bichlorid solutions, iodoform and turpentine have been employed. The practice has not come into general use.

Chloroform has been administered for the relief of pain, and Bartholow recommended the use of ethyl iodid by inhalation, chiefly on account of its anesthetic and antispasmodic properties.

Treatment by systematic cold or tepid bathing, as practiced by Jurgensen at Kiel and Tübingen, and shown by certain series of statistics to have resulted in an apparent reduction in the mortality amounting to fifty percent, has never come into general use either in Germany or elsewhere. Our experience with systematic cold bathing in selected cases of croupous pneumonia in the German Hospital in Philadelphia has been almost uniformly unfavorable to that method of treatment, which has consequently been abandoned.

The local application of cold to the surface of the chest over the affected lung—an old method of treatment recently revived in this country—has many advocates. Niemeyer, who used cold compresses to the affected side frequently renewed, regarded the measure as of great value in relieving pain, reducing the temperature to some extent, and in shortening the course of the attack.

The application of several suitable ice-bags, so as to surround the affected chest, is a more convenient plan. I can, from my observations, bear witness to the fact that this use of cold relieves pain, and to some extent controls the febrile movement. That it arrests the spread of the exudate or shortens the course of the attack, I do not believe. It is certain, however, that it is agreeable to the patients, and is frequently followed by relief of restlessness, and a tendency to sleep. I employ it as a matter of routine, except in mild cases with slight pain, in children, or in cases in which there is some distinct contraindication.

Medicinal antipyretics of the coal-tar group were for a time extensively

employed in the treatment of pneumonia. Their use is of questionable propriety, any theoretic advantage derived from the ensuing transient reduction of temperature being more than offset by their depressing effects. The importance of the high temperature has been over-rated. Welch (Cartwright Lectures, 1888) has carefully analyzed the experimental and clinical data bearing upon this subject. He shows that animals may be kept at a high temperature for at least three weeks without manifesting serious symptoms. The functional disturbances to be attributed directly to the influence of elevated temperature are increased frequency of the respiration and quickened pulse. No definite relation can be established between the variations of arterial tension which occur in fever and the height of the temperature. Though prolonged high-temperature is an element in the causation of fatty degeneration of the heart, there are other factors, such as infection, concerned in the production of the lesion. The lessened perspiration, the renal disorders, and the digestive disturbances, with the possible exception of constipation, are always referable chiefly to other causes than the increased temperature. Both experimental and clinical observations strongly support the view now widely accepted that the disturbances of the sensorium, which constitute so prominent a part in the group of so-called typhoid symptoms, are dependent in a far greater degree upon infection or intoxication than upon the heightened temperature. In support of the conclusions derived from the experimental study of the effect of heat upon men and animals, Dr. Welch called attention to the absence of all serious symptoms in many cases of relapsing fever, and in the so-called aseptic fever, in spite of prolonged high temperature. In conclusion he emphasized the fact that in those fevers, such as typhoid fever and pneumonia, in which the height of the temperature is undoubtedly a most important index of the severity of the disease, there exists no such parallelism between the temperature and the nature and severity of the other symptoms as we should expect if these symptoms were caused by the increased heat of the body.

It is a matter of common observation that in the so-called typhoid pneumonias, which constitute one of the groups in which the mortality is excessive, and which are of gradual onset, the temperature usually attains a very moderate elevation, 101 degrees to 103 degrees F.

Croupous pneumonia is a self-limited disease. There is no remedy or method of treatment of which it can be positively said that it is capable of aborting the attack. The milder cases run a favorable course and get well without the use of perturbing remedies. The treatment must in the present state of knowledge be expectant. This expectancy cannot be idle; it must be alert and vigilant and abundant in resources.

Jurgensen as long ago as the writing of Ziemssen's Cyclopedia, at the conclusion of a masterly demonstration of the infectious character of croup-

ous pneumonia as against the old view of its being a local inflammation, alludes to the unknown infecting principle. Later he lays down the simple rule of treatment that in this as in other self-limited diseases the first duty of the physician is to endeavor to support life until the attack has run its course. Since that time the nature of the infecting principle has been revealed to us, but this knowledge has contributed almost nothing to our therapeutics. We must still support the patient and await the crisis. We in our turn may look forward to a time when a clearer understanding of the mechanism by which the pathologic process works itself out from the local cause to the local and general symptomatology will render treatment more definite and fruitful. In this connection one thinks among other things of the leucocytosis and notes the repeated observation that in the worst cases this blood-change does not take place. Meanwhile the indications for systematic treatment are to be found in the evidences (a) of interference with the respiratory function, (b) of interference with the circulatory function, (c) of interference with the functions of the nervous system, (d) of interference with the excretory functions. Of fever, even though it be high, we take less account. We bear constantly in mind that the functional disturbances relating to the respiration and circulation are largely, though not wholly, mechanical, and we never lose sight of the fact that the disturbances of the nervous system and of excretion are due to soluble chemical substances, toxins circulating in the blood. This distinction between mechanical and toxic phenomena removes a stumbling-block in the way of our understanding that some cases with extensive local lesions recover, while others with limited local lesions die.

A few words of the hygiene of the sick-room. It should be large and well lighted, though the light should be controlled to suit the sensations of the patient. It should be well ventilated. The patient is not liable to take cold, and requires above all an abundance of fresh air. The bed-clothing should be light and varied from time to time in accordance with the sensations of the patient. The food should be of the simplest and most digestible kind—the nourishing liquid diet of the fever-patient, administered systematically, but in sparing amounts. Cool, effervescing drinks—seltzer, apollinaris and the like—should be given as freely as the patient cares to take them. At the onset the patient should receive a laxative dose of calomel, 5, 7½ or 10 grains (.3 .5 or .7) followed, if necessary, after some hours, by a saline in concentrated solution, and after this 2 or 3 grain (.15-.2) doses of Dover's powder at intervals of two or three hours, according to the urgency of the pain and cough. The application of ice-bags to the affected side of the chest should be at once made. These measures constitute in more favorable cases the whole treatment. The deodorized tincture of opium in corresponding doses, or codein hydrochlorate, or the occasional hypodermic injection of small doses of morphin, may seem preferable to the Dover's

powder in certain cases. The repetition of a laxative may be necessary from time to time during the attack. Alcohol is essential to patients who have been accustomed to its use, very often desirable in those who have not. Properly administered, it is the best of the cardiac tonics. The patient should have a sponge bath under the bed-coverings morning and evening; oftener if the temperature be high; a cold pack if it be excessively high. By the third or fourth day, if pain be less urgent, the ice-bags may be removed. I very seldom find drugs of the so-called expectorant group necessary. Upon the occurrence of the critical defervescence, alcohol in freer dosage, ammonium carbonate and the external application of heat may be necessary.

The convalescence is usually rapid, the signs of consolidation disappearing more slowly than the symptoms. The patient, in the absence of delayed resolution or secondary infection, soon comes to regard himself as well.

Such is the plan of treatment that I have employed in the milder cases in hospital and private practice for some years. There is nothing in it specific, nothing perturbing. The small doses of opium relieve pain, sufficiently control cough, and combat the nervous erethism, from which the patients often suffer. The calomel stimulates excretion by the alimentary tract, to some extent also by the urinary tract. The ice-bags, the cold sponging, the occasional pack, exert a favorable but no very potent action upon the pyrexia. Notwithstanding these measures, when all its details are summed up, the treatment may fairly be regarded as expectant. It is but little varied during the course of the attack, nor do I see much to gain in dividing the treatment into periods corresponding with the anatomic lesions, as some teachers have done, since the boundaries between these stages are less distinct clinically than anatomically.

The mildest cases in young adults, with little pain, moderate cough and no delirium, may be treated upon a purely expectant plan without drugs.

When certain symptoms or symptom-groups become severe the treatment must be correspondingly modified. It then becomes expectant-symptomatic. The symptoms relating to the mechanical disturbances of the respiration and circulation are more liable to be intensified in the beginning of the attack; those attributable to the toxemia, later in its course. It often happens that a rapidly developing exudate causes cyanosis and extreme dyspnea by rapidly restricting the area of the respiratory surface and rendering impermeable a large part of the pulmonary circulation. It is not without interest to note that this condition arises more frequently in large-framed, deep-chested individuals with voluminous lungs and a great mass of blood. The indication for treatment is obvious. Free venesection at once accommodates a diminished mass of blood to the restricted channels of the pulmonary circuit, relieves the struggling right heart, and is followed by notable amelioration of the urgency of the symptoms. Blood-letting, to produce its favorable effects, should be done early, and as a rule, to which

there are almost no exceptions, once for all. If the volume of blood thus diminished fail to adjust itself in some way to the altered conditions of the pulmonary circulation there is little hope that success will follow repeated bleedings. A large proportion of the blood of the organism, and especially of its corpuscular elements, is taken out of the circulation in the formation of the exudate. Each act of venesection diminishes the number of red blood corpuscles, and further impairs the oxygen-carrying function of the blood. The local abstraction of blood by means of leeches applied to the affected region is inadequate to relieve urgent symptoms at the beginning, and is chiefly useful in the relief of pain.

The over-distended and flagging right heart calls for the free use of alcohol, best in the form of whisky, or, if the patient prefer it and circumstances permit, as champagne.

Strychnin stands foremost in the list of heart-sustaining drugs. The sulphate of strychnin may be given by the mouth in doses amounting to one-tenth of a grain in the course of twenty-four hours, with an additional hypodermic dose of one-thirtieth of a grain at intervals of twelve or eight hours.

Digitalis has not proved satisfactory in my hands, and its use should be reserved for special indications, only to be determined by a careful investigation of individual cases. Caffein citrate in doses of two or three grains every second or third hour sometimes produces very favorable effects upon the heart, at the same time causing diuresis. The effects of caffein are, however, less permanent than those of strychnin.

The occasional administration of a small cup of strong, black coffee exerts a favorable influence alike upon the circulation and upon the nervous system. Care must be taken, however, lest sleeplessness be induced or increased.

It is in accordance with our present views as to the disturbances of the circulation in croupous pneumonia that the nitrites are coming to be more and more employed. Nitroglycerin or amyl nitrite may be given in doses cautiously increased until obvious but transient effects follow, and because of the transient nature of their action the repetition of the dose should be at comparatively short intervals. Later in the course of the attack sodium nitrite, because of its slow and more persistent action, is preferable.

In this connection the question of so-called counter-irritation and other applications to the surface of the chest may be properly considered. I have been unable to convince myself that sinapisms or turpentine stupes, even when they produce distinct reddening of the skin, exert any favorable influence upon the respiratory symptoms or the course of the attack. The same is true of poultices. Both are inconvenient to apply and usually annoying to the patient. I have long since abandoned them. I have likewise given up the use of the cotton jacket and the oiled silk jacket, even in chil-

dren. These appliances are inconvenient and uncomfortable and soon become unclean. Practically, I have seen them do no good, and theoretically, I know of no purpose that they can serve save, as it is claimed by some, that they prevent chilling of the surface—a danger in itself largely theoretic—which can be far more satisfactorily guarded against by a merino undervest of moderate weight.

If the pleural pain be excessive, it may be necessary to administer morphin hypodermically, or to apply two or three leeches as indicated above.

Nervous symptoms may develop early and be sufficiently severe from the onset to require special treatment. The restlessness and apprehension, so distressing to many patients, is best relieved by the administration of opium or its derivatives. Delirium demands increased alcohol, together with ether hypodermically, or the cautious use of the bromids in combination with small doses of chloral, which are useful also in the management of headache and sleeplessness. If there be great restlessness and jactitation hyoscin hydrobromate may be given hypodermically along with small doses of morphin. I have seen all these measures fail and relief follow the use of water. Sometimes the tepid bath has been followed by quietude and refreshing sleep; sometimes a cold pack or the rapidly cooled bath has given relief that drugs failed of. Perhaps the most remarkable results of hydrotherapy in my experience in the treatment of croupous pneumonia have been those following the cold douche—a measure, the mere mention of which strikes horror into the minds of the patient's friends. The patient is lifted upon a cot suitably arranged with a mackintosh or rubber sheeting, the clothing is removed from the upper part of his body, and water of the temperature as drawn from the cold spigot is poured over his head, face, neck and shoulders, from a pitcher at the height of twelve or fifteen inches, and to the amount of three or four liters. The patient is then dried, fresh clothing put on him, and he is returned to his bed. Delirium, tending to coma, has rapidly yielded to this treatment, the patient regaining consciousness, with deeper breathing and a fuller pulse. After some hours, if stupor returns, the process may be repeated. I speak without undue enthusiasm when I say that I have seen several lives apparently saved by this measure.

A small pleural effusion, before which the consolidated lung cannot yield, may seriously add to the difficulties of the situation. When dyspnea is aggravated the possibility of such a condition should not be overlooked, and its signs should be carefully sought for. Great relief frequently follows the removal by aspiration of relatively small amounts of fluid.

If resolution be delayed, flying blisters may be employed over the affected side, and pilocarpin, the iodid of potassium or the iodid of iron may be administered.

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## The Complications of Purulent Otitis Media

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BEFORE considering the complications of purulent *otitis media* let me call attention briefly, but with emphasis, to the uncomplicated form of the disease and for the purpose merely of insisting upon the importance of the early and thorough treatment of pus in the ear in order, if possible, to prevent these later and graver consequences. For no reason, either because of a great respect for the old and widespread superstition that to check a running ear is to drive the pus to the lungs or brain, or because we may think that a freely discharging ear is in the best possible condition for the relief of the inflammation, should we allow a purulent *otitis media* to progress to either a bad or a good result without attention. In other words, pus-collection and discharge in and from the ear should receive not less and later, but greater and earlier attention than an abscess in other parts of the body, for the reason that it is less liable to get well without such attention, and also because the consequences of neglect are, in the general run of cases, more disastrous. In no class of cases does a patient suffer more or longer from inattention or from a mistaken conservatism of his physician.

Whether it is advisable to treat the diseased ear by the dry method or by syringing, or by the instillation of antiseptics and caustics, or by operation I cannot undertake to say, for, to my mind, it is a mistake to pin our faith to one form of treatment when all those recommended have a value, at least in some cases. I wish merely to insist that by cleansing and by applying appropriate antiseptics, or by operating, we may consistently try to cure the purulent condition before the complications of suppurative *otitis media* appear. These are too numerous and their importance too considerable to allow of the consideration in detail of the entire subject in a paper brought within the limits required by this society. With a passing mention, then, of the more frequent *sequelae* and accompaniments of purulent middle-ear disease, I will consider more fully three complications which, though fortunately of rarer occurrence, are the most serious and dangerous of these complications, namely, cerebral and cerebellar abscess, septic thrombosis causing pyemia, and meningitis.

While the middle ear is in a state of acute inflammation with no perforation of the tympanic membrane or with one insufficient to carry off the products of this condition, the mastoid cells and antrum are in danger of being made the receptacle of this discharge, and in like manner obstructed discharges of a chronic inflammation gravitate to these parts. The recog-

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tion of mastoiditis is not difficult, and its treatment must be energetic. Thorough opening of these bony cavities must quickly follow the failure of treatment by leeches, paracentesis and the application of cold.

Long-continued inflammation of the tympanum causes, in other cases, caries and necrosis of its walls or its bony contents, and this process, too, may involve the mastoid region. When, by means of the probe or because of the long-continued and intermittent discharge, our diagnosis is made, and the disease does not yield to local treatment by antiseptics, we must proceed to operate, either by excision of the carious ossicles or by the removal of the *sequestra* from the tympanic walls or mastoid process. For this purpose our best method is probably by Stacke's operation, or one of its modifications, and consists of thoroughly exposing the tympanum, attic, and mastoid antrum and leaving them connected and exposed to drainage through the external auditory meatus as one cavity, and at the same time carefully cleaning out all carious ossicles and necrotic spots in tympanum and mastoid.

*Granulations* and *polypi* arise often in the course of purulent middle-ear disease to complicate the case. *Polypi* of the mucous type are probably comparatively rare, and these tumors are generally granulations with an amount of connective tissue varying with their duration. They are generally easy of removal, but their recurrence is only prevented by thorough treatment of their cause, *i.e.*, of the chronic suppuration.

*Cholesteatoma*, collection and impaction of epithelial debris mixed with cholesterin, acts as a foreign body and needs removal before we can cure the case.

*Facial paralysis*, generally the result of necrotic erosion of the thin, bony canal containing the facial nerve, situated on the inner and posterior wall of the tympanum and subsequent pressure upon the nerve-trunk or inflammation of its fibers has been often observed and reported. The prognosis will depend on the amount and permanency of the damage suffered by the nerve.

Other complications, due more or less directly to suppurative *otitis media*, may be mentioned in passing, hemorrhage from the internal carotid artery on account of necrotic destruction of its bony wall in the ear and ulceration of its coat; general pyemia with multiple abscess in the liver and elsewhere; amyloid degeneration due to prolonged suppuration. Good authorities consider that malignant disease is especially liable to affect an ear weakened by constant and long-standing suppuration.

Of the three complications which I desire especially to consider in this paper it is probable, from statistics, that abscess, either cerebral or cerebellar, is slightly more frequent than the other two, but it must be said that in a great number of cases two or even three of these troubles occur together. Meningitis may result from the acute form of suppurative *otitis media*, but is more frequently a consequence of the chronic form with bone-necrosis.



and this latter form may be considered as always the causative factor in brain-abscess, and sinus-thrombosis dependent on ear diseases.

The path for the extension of the suppuration to the brain or its meninges or to the sinuses from the ear is generally directly through disease of bone, and for this reason in necropsies of cases of this kind the collection of pus has, in the great majority of cases, been found in that part of the temporo-sphenoidal lobe of the brain lying over the tympanum, or extradural in the same vicinity. Other means of communication between the tympanic cavity and the brain and its meninges exist; for instance, vessels and nerves and processes of fibrous tissue extending towards the tympanum through its roof.

An early differential diagnosis between these lesions of the brain is obviously important, and to that we may devote the remainder of this paper, leaving the treatment, which must be active and heroic, in the hands of the general surgeon.

Abscess symptoms may last from a few days to several months. In a patient the subject of an old suppurative *otitis media* the following train of symptoms should make us strongly suspect the existence of a collection of pus in the brain. An increasing irritability and restlessness, a dull intellect, headache usually of a sharp and lancinating character, drowsiness, vomiting without apparent cause, emaciation, and in final stages convulsion and delirium. Very slight chill may be present, but real rigors indicate the presence also of septic thrombosis. An important symptom, if present, is aphasia, produced probably by destruction of the auditory centers in the temporosphenoidal lobe and consequent so-called word-blindness. In many cases failure of memory has been noted. Paresis or tremors also aid us, by their character and site, to come to a diagnosis of some lesion affecting the motor area or motor nerve-trunks. Optic neuritis is not a symptom often seen in abscess of the brain, but may occur, more particularly in cerebellar abscess.

It must be remembered that many of the symptoms outlined are present in case of brain tumor without the presence of pus-collection, as has lately been commented upon by Burnett,\* and this author cites two cases under the care of European observers in which the existence of some of these symptoms, accompanied by old suppurative *otitis media* led the observer to operate for otitic cerebral abscess, when the necropsy revealed tumors of the cerebrum and cerebellum. In such cases Burnett points out that we should be able to come to a correct diagnosis between abscess and tumor of the brain, chiefly by means of the longer duration of the symptoms of tumor, and also that choked disk leads us to suspect tumor or phlebitis, especially if interfering with the circulation in the cavernous sinus or ophthalmic veins. Slight rise of temperature has been noticed at times in the course

\*University Med. Mag., No. 6, Vol. VIII., p. 422

of an otitic brain abscess, but much more frequently normal, or even sub-normal, temperature is present. A rise of temperature should lead us at once to suspect the occurrence of meningitis.

As to the ear itself, we would be likely to have the history of the stoppage of an old purulent discharge sometime previously, attributable to cold, trauma, foreign body (cotton), etc., or possibly through an operation for removal of polypi or ossicles. This acute process causes a swelling of the mucosa, damming back the discharge, and by septic inflammation of the petrous or mastoid bones and their contents gives rise not only to abscess, but also to either or both of the other brain lesions of ear-disease, namely, meningitis or sinus-thrombosis.

Locally, pain on palpation is present when the pus is confined under tension in the bony parts adjacent to the brain, but as a symptom of abscess itself it is not to be relied upon. The site of these pus-collections is, in the great majority of cases, as pointed out by Pitt\* in an able review of the whole subject, in the temporosphenoidal lobe and close to the roof of the tympanum; and in addition to the abscess in this locality there is nearly always a localized slough of the *dura mater* over the same site. Localized collections of pus have been found both subdural and in contact with the inner meningeal surface, and also imbedded in the brain substance, separated from the *pia mater* by strata of sound brain-substance of varying thickness. This difference is, I presume, to be accounted for by the fact that the abscesses lying in close juxtaposition to the diseased bone have, as a cause, the spread of the septic process directly from necrosed bone and from sloughing membrane, while those more remote are probably caused by infecting material carried along the vessels or perivascular lymph channels. And secondary abscesses reported to have been found in certain cases, as well as those found in unusual sites, have probably a like indirect etiology.

The view held by Toynbee that the brain complications of purulent *otitis media* can be diagnosticated as to their location from the part of the ear or mastoid process affected has not proved true according to the investigation of later writers.

*Sinus-thrombosis.* An embolus carried to one of the sinuses of the skull, generally the lateral, causes a thrombosis of that sinus, and, coming from a field of purulent material in the ear or from an already existing abscess of the brain, it is generally septic, and causes a septic thrombosis which, in turn, infects more distant organs.

In a large proportion of the cases reported when necropsies have followed, the disease has been found to depend on old suppurative inflammation of the tympanum with necrosis of its posterior wall.

We may have in thrombosis of sinus a train of symptoms in many respects like those observed in abscess of the brain. Thus, headache, vomit-

\*Br. Med. Journal, March 22 and April 5, 1889

ing, restlessness, listlessness, convulsions and delirium are sometimes all found, but the onset of the disease is more sudden and its course shorter. Symptoms distinguishing thrombosis from abscess, however, are present in the majority of cases. Thus, when the thrombus is a center of septic infection, as it usually is, rigors, pyrexia and a gradually increasing condition of septicemia follow, the latter especially when septic pneumonia has been induced.

By the mechanical action of the pressure, caused by damming back the blood flowing into the sinus, we have symptoms of congestion of the tributary veins in edema and hyperemia of the parts drained by them, and I think it is due to this that we frequently have optic neuritis as a symptom of sinus-thrombosis. Hemorrhage from the nasal *mucosa* is explained by the same cause, as are also, in certain cases, great swelling and edema of the face and neck, and other more obscure and infrequent symptoms.

*Meningitis.* Here we have a complication of suppurative *otitis media*, more frequent in children than either sinus-thrombosis or abscess of the brain. It may, unlike the other two affections, be the result of an acute *otitis media* of severe grade, or it may, like them, come from the chronic form of the disease, or it may be observed as the fatal result of either abscess or thrombosis.

The onset and course of a meningitis need not be dwelt upon, save to point out the difference between it and abscess of the brain and thrombus. The acuteness of the attack and rapidity of the progress of the disease differentiate it at once from the former, and in a less degree from the latter. The pain is dull and distributed, and therefore unlike the sharp and lancinating pain of abscess. The temperature tends to hyperpyrexia, but not to fluctuation as in thrombosis with septicemia. The classical symptoms of meningitis, retraction of the head and rigidity of the cervical muscles, are generally present. Contracted pupils are the rule, but optic neuritis is generally absent.

Distinguished thus in its early stages by symptoms distinct from the other two affections under consideration, otitic meningitis runs a rapid and in the majority of cases a fatal course, and has in common with the other affections towards its termination as symptoms delirium, convulsions and coma.

Green\* has ascribed to meningitis, due to suppurative *otitis media*, two possible methods of causation from infection. One by vascular absorption of the morbid material, and the other by direct contact infection from diseased bone; and he points out, with a view to treatment, the fact that the latter is a much more limited, and therefore more easily controlled process than the first, and argues that, while their symptoms are indistinguishable, we should, when operation promises any benefit, undertake it at the earliest possible moment, hoping that we have to deal with the latter variety of men-

\*Boston Med. Journal, June 19, 1890

ingitis, and may, therefore, look for a favorable termination.

Otitic meningitis may, if the cause of irritation is removed before the process has progressed, yield to treatment by the means usually employed to control meningeal inflammation arising from other causes. Its course is, however, generally extremely rapid and fatal.

The proper surgical treatment of brain abscess by trephining the skull and evacuating the pus, and that of thrombus of the sinus by opening and washing out the sinus, belong to the domain of the general surgeon, but the early and correct diagnosis of all of these conditions must be made by the specialist or by the general practitioner, in order that the surgeon may have for his operation even a fair chance of success.

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## Notes on Dermatoses Due to Vegetable Parasites

### Their Role in the Evolution of Modern Pathology

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THE history of dermatology is the history of medicine, for diseases of the skin being visible to the eye were the first to be recognized and the first to receive accurate description. So important were they that a special treatise was devoted to their consideration as early as 1572 (a). True, it was not original research, any more than are the treatises of today, but a compilation of the teachings of Hippocrates, Celsus and Galen, and as such was a valuable contribution to medical literature.

The first departure from the humoral pathology in medicine occurred in 1839, when Schönlein of Zurich, later of Berlin, announced the discovery of the *oidium*, afterwards named *achorion Schönleinii* by Remak, in honor of the discoverer. There were not wanting at the time, men of high repute who ridiculed the idea of favus being due to a vegetable parasitic growth. Nor have some more modern writers been willing to accept the germ theory of disease. Sir Erasmus Willson as late as 1881 maintained that the so-called vegetable parasitic diseases of the skin were in reality not due to extraneous growths, but that the microorganisms found represented the various processes of cell-degeneration as promulgated in the pathology of Rokitsansky in 1842. Finally, the study of the Hyphomycetes or fungus family, revealed the Schizomycetes or bacteria which constitute one of the main factors in the pathology of today.

For half a century the vegetable parasitic dermatoses have been the

object of investigation, diversity of opinion and discussion, yet with improved methods and appliances much additional light has of late been thrown on the subject which, with the most successful methods of treatment, will comprise what I have to say.

**FAVUS** is an uncommon disease in many countries, and in the United States is only seen in recent arrivals from countries such as Russian Poland, Scotland, France and Italy, where the disease is endemic. The lesions when well-developed are characteristic and are composed of sulphur-yellow, pin-head-sized bodies situated at the base of the hair follicles, usually on the scalp, although no part of the body is exempt. White of Boston, has encountered the disease on the glans penis, and Kaposi reported a case of gastro-intestinal disturbance in which the necropsy revealed colonies of favic fungus in the mucous membrane of the esophagus and stomach. As the disease progresses the yellow grain-like bodies increase in size by peripheral development, while the central part becomes depressed; in this way the cup-shaped crusts or *scutulae* are formed. These, when present, render the disease easy of diagnosis, and as they are invariably present, unless the affection has well-nigh disappeared by spontaneous evolution, the recognition of favus need not longer engage our attention.

The achorion of Schönlein comprises many different forms of mould fungi, which by certain writers, Quinke (*b*), Unna (*c*), and Sabrazès (*d*), are supposed to be distinct varieties, giving rise to as many forms of the disease. The majority of dermatologists, however, hold to the view that there is but one favic fungus, composed of several elements, and producing one clinical variety of the disease.

**TINEA TRICHOPHYTINA** is a disease of great practical moment, because in its various forms it is often difficult of diagnosis, and because it is a very common affection. Gruby (*e*) of Paris, and Malmsten (*f*) of Stockholm, almost simultaneously discovered the parasitic nature of the disease and described the parasite. By the latter the fungus was called *trichophyton*, which name it still bears. Like the fungus of favus, the trichophyton is made up of mycelium and spores. The former appear under the microscope as long, slender, colorless, usually well-defined threads, which are straight or tortuous, sometimes forked, and vary both in length and width. At times septa are seen, between which one or more pale nuclei are sometimes visible.

The pathology of *tinea trichophytina*, as well as the clinical picture of the disease, varies according as the scalp, the bearded part of the face, or the smooth surfaces are involved. It is generally understood that these differences may be accounted for on anatomic grounds, but of late, Sabouraud (*g*) has described three or more distinct varieties which are dependent on the special microorganism found therein. Two main varieties are given: the large cell, or true trichophyton, 7 to 9 m.m., and a small variety, 2 to 3 micro-

millimeters, which he does not regard as a trichophyton, but a *microsporon audouini*, first described by Gruby. The large-celled variety gives rise to two clinical forms of the disease: (a) mild form situated on the smooth surfaces usually during childhood; (b) always of animal origin and when derived from the horse, giving rise to a highly pyogenic folliculitis, as in *tinea barbae* and kerion of the scalp. A milder form, also composed of large cells, is contracted from the cat, which may be recognized by its superficial situation giving rise to vesiculation, etc. The small-celled variety, or *microsporon audouini* gives rise to *tinea tonsurans* in children, is highly contagious, and is the most rebellious of all to treatment. It attacks only the upper layers of the epidermis and the hair substance, and does not produce permanent baldness. Quite recently Mibelli (*h*) has verified the plurality of the fungus in *tinea trichophytina*; he does not, however, accept in full the claims of Sabouraud.

Considering the subject *seriatim*, the lowest form of development is met with when the trichophyton attacks the general body surface. Following its natural tendency to select structures that have undergone keratization, the corneous layer of the epidermis is involved. It shows little tendency to attack the rudimentary hair-follicles, or to penetrate below the horny layer. Under the microscope the fungus may be clearly seen with a 1-6 inch objective. It is composed of long, somewhat tortuous mycelia with but few spores; it becomes intractable only when lodged in parts such as the axillae, the inner surface of the thighs, etc., where heat and moisture produce the greatest luxuriance in vegetable growth.

In ringworm of the scalp the hair becomes early involved, leading to disorganization of the hair-shaft and penetration into the follicle; under the microscope the stumps of hair are found thickly infiltrated with spores, while few mycelia are seen. The obstinacy of the disease depends upon its penetration below the surface. When the beard is invaded there appear to be two distinct phases of the disease, which some suppose to be distinct varieties. The first involves the superficial strata of the scarf-skin, forming rings, and reddish, well-defined patches, which yield readily to treatment; while the second is an intractable disease, penetrates deeply into the follicle, and attacks the bulb of the hair often before any impairment of the free shaft takes place.

It is a question on which opinions differ whether or not these two phases of the affection are due to the same fungus. Clinical observation inclines one to the belief that there are two distinct varieties of *tinea barbae*, the one attacking the surface, corresponding to *tinea circinata*, the other attacking the fundus of the follicle, corresponding to the variety known as kerion of the scalp, which is a suppurative folliculitis, due to the presence of the trichophyton. Onychomycosis is comparatively infrequent, and difficult of diagnosis, because it does not differ in appearance from diseases of the nail caused

from psoriasis, eczema, *lichen ruber*, or traumatism. In onychomycosis, however, the nail is usually primarily involved, or occurs in one having some form of ringworm elsewhere. It makes its appearance at the side of the nail under the fold of the skin, the nail becomes dark, lusterless and brittle, fissured and broken. One or more nails may be subsequently involved, seldom all the nails of the hand, while in diseases of the nail supervening on psoriasis, etc., all the nails are usually affected. In making a diagnosis, scrapings from the diseased part of the nail should be washed in ether, dissolved in *liquor potassae* and placed under a one-sixth inch lens, when the fungus may be readily seen.

**TREATMENT.** The management of all the vegetable parasitic dermatoses may be considered under one heading, because the principle of treatment is the same in each. True, some parasites are more easily destroyed than others, yet the main difference unquestionably depends upon the depth to which they penetrate. In all, the first care is to prevent the disease from spreading to other parts of the body, or to those unaffected. Thus at the onset it is advisable not to shave the parts affected lest new foci spring up from autoinoculation, but when occurring on the bearded part of the face or scalp the hair should be closely clipped over the diseased area, extending fully half an inch beyond the margin. For this purpose Crocker (†) and others recommend an impermeable dressing of traumaticin or flexible collodion in which one of the parasitocides, to be spoken of later, is incorporated. The act of washing also is a source of danger. As a precaution, it is well to bathe the parts with some antiseptic substance, dissolved in alcohol, such as boric acid, carbolic acid, or the bichlorid of mercury. It is necessary also, from time to time, to change the lining of caps and other articles of clothing that come in contact with the affected part. The comb and brush should not be used, but instead, the hair of the scalp in children and the beard of adult males should be worn closely clipped.

When the disease is situated superficially, as in *tinea circinata* and in the early stage of *tinea barbae*, attention to cleanliness, together with the application of some mild parasiticide, such as sulphur, boric acid, or a saturated solution of hyposulphite of soda, suffice. In this class come also *tinea versicolor*, and erythrasma. When the parasite has penetrated more deeply, involving the lower strata of the epidermis or follicular openings of the hair, as in *tinea favosa*, more energetic measures should be adopted. Here all crusts must be removed, by first soaking in salicylated oil (gr. ij to castor oil 3j). It has long been known that substances having an irritating effect on the skin are efficient as parasitocides. It is now well understood that with many their action is indirect, as it is the subsequent inflammation with the formation of pus which changes the soil in such a way as to be inimical to the life of the fungus. Again it appears that pus itself is a potent germ destroyer. Thus, croton oil, tar, mercury, and chrysarobin are efficient in this group.

Chrysarobin is undoubtedly one of the best parasitocides, although care must be taken when using it on the scalp or face, lest it extend to the eyes, or cause a too severe dermatitis in delicate skins. Another disadvantage is its property of staining. From ten grains to a drachm, to the ounce of vaselin or traumaticin may be used. The latter forms an impermeable covering and prevents the drug from spreading to the unaffected parts.

When the root of the hair is involved, as in *tinea tonsurans*, *tinea barbae*, etc., applications which act only on the superficial strata of the skin are not sufficient. Either epilation must be persistently followed or the parasiticide must penetrate deeply into the follicle. Various methods and devices have been used for this purpose, such as the galvanic current of electricity, atmospheric pressure, etc., although, according to my experience, the best is a vehicle composed of the following:

R. *Ol. Amygdalae dulcis*, ʒij,  
*Lanolin. adde*, ʒj.

On account of their osmotic power, the oleates are highly esteemed in the treatment of deep-seated parasitic growths. Of these copper (ʒi to ʒi) is highly spoken of by some, while twenty percent of the pure oleate of mercury, to the ounce of the vehicle above mentioned has given me the best results.

In purulent folliculitis, as in *tinea barbae* and kerion of the scalp in children, as previously stated the suppurative process will of itself eliminate the fungus. Certain accessories are, however, required to complete the cure, such as epilation in which all the diseased hairs are removed, and absolute cleanliness lest the disease extend to the sound parts, thus propagating itself indefinitely. In this latter process baldness follows from destruction of the hair *papillae*.

In the treatment of onychomycosis, the diseased part must first be removed, either by scraping, or by the complete removal of the nail itself. When the seat of the disease is reached applications of oleate of mercury or chrysarobin as above given may be used. *Liquor potassae* is also of service. It may be applied with lint, after which the nail may be readily scraped away. Sulphurous acid or the hyposulphite of soda, ʒii to the ounce of water, may also be applied with lint and covered with oiled silk. Whichever plan is adopted care must be taken that the parasiticide comes directly in contact with the diseased part.

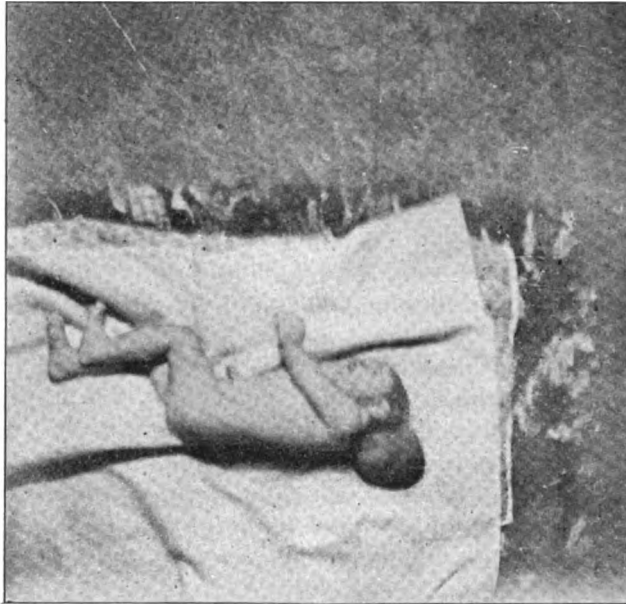
- a. Mercurialis, *De Morbis Cutaneis*.
- b. Quinke, *Monatsheft f. prakt. Dermat.*, 1887, Nos. 2 and 22.
- c. Unna, *Monatsheft f. prakt. Dermat.*, 1893, Nos. 1 and 2.
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- f. Malmsten, *Muller's Archiv.*, 1848.
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- h. Mibelli, *Annal. de Derm. et de Syph.*, Aug. and Sept., 1895.
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## Report of a Case of Labor Complicated by Hydrencephalocele

BY OSCAR HASENCAMP, M. D., TOLEDO

I WAS called, December 26, 1894, to attend Mrs. J. S., in labor. She is a strong, robust German woman, thirty-five years of age, and had one child in a previous labor in which I attended her October 30, 1893. The first labor was tedious, and I had to deliver with the forceps, but the child was well-formed, and the mother passed the usual time in bed without further trouble and regained her usual health and strength. The child although well at birth became sick with cerebrospinal meningitis about a month after birth



and died on the second day of the disease. When I made an examination on the morning of December 26, 1894, about 4 A. M., I found her suffering from regular pains, but the os was not dilated, so I gave her an opium suppository, one grain, and told her I would see her later in the day. I returned about 8 P. M., and found that she had rested well several hours during the morning, but that she had been having pains nearly all day. On examination I found os slightly dilated and membranes not ruptured, with so-called "glove-finger" protrusions during each pain. I could not feel the occiput by vaginal touch, and by palpation the child seemed to lie in the right occipital anterior position. I made up my mind that I had something unusual. I gave another opium suppository with instructions to use about

10 o'clock, as pains seemed to get weaker, and I left the patient with instruction to call me when pains became stronger. I was called again the next morning and found the patient had rested well the night before, and pains were quite strong. The os was dilated to about the size of a silver dollar and everything progressing favorably, except that I could not feel the presenting part and could only make out a soft mass through the membranes. I gave five grains quinin sulphate and left the patient, but returned again in about two hours. Everything was progressing nicely and pains became stronger. The membrane ruptured about noon and a soft tumor filled the vagina and by 3:30 P. M. the child, which was dead, was completely delivered. (I herewith present photographs which I took several hours afterwards by the aid of a small hand camera and a magnesium flash-lamp. You will notice two views of the child as I placed it on a small white cloth laid on the floor.) The tumor which I mentioned proved to be a large hydrencephalocoele and, as you will notice by the photograph, larger than the child's head, although it was not quite so large when the picture was taken as at birth, on account of a small rupture of the skin that occurred, probably during labor, which allowed the fluid to slowly escape. The tumor was joined by the neck-like attachment about the median line to the occipital region. The tumor measured sixteen inches in circumference taken at the longest superior inferior diameter, and it was covered with hair like the scalp. I was unable to have a postmortem, but by making a small opening I found that the tumor contained fluid and a small protrusion of brain substance. I present this case more on account of its rarity than for any other reason, Trelat finding, for instance, but 3 in 12,000 births, and Vines 1 in 5,000, and more common in females than males.

902 Cherry Street

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## The Erudite Touch

BY S. J. WRIGHT, M. D., TALLMADGE, OHIO

THE popular phrase, "as true as touch," and the proverb, "seeing is believing, but feeling is the naked truth," contain a modicum of truth in scientific investigations. The scientifically perfect touch is yet to be attained, by laborious methods aided by instruments and apparatus yet to be devised. Courts of law are frequently occupied in the effort to decide between experts, as to which possesses the erudite touch in the highest degree. And if the righteous expert scarcely is saved, where shall the ungodly and general practitioner appear? The sense of *sight* is aided by artificial means, telescopic, microscopic, endoscopic and diascopic; and where the retina fails, the sensitive photographic film avails. The sense of *hearing* is

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*Read before the Union Medical Association of Northeastern Ohio, at Canton,  
June 9, 1896*

supplemented by stethoscope, microphone and ear-trumpet. To supplement the deficient sense of *smell* the hound is called into requisition. But the sense of *touch* exists in greater or less degree, according to the *experience* of the possessor.

The general practitioner is no longer made conspicuous by peculiar dress or a gold-headed cane. Bacteriology has enabled the general surgeon to take from his exclusive control the great cavities of the body. And workers in the special departments of surgery have still further encroached upon the field of labor once occupied by the general surgeon.

"Especial sensitiveness of touch acquired by long experience." (a)

"Touch in the wide sense gives man his knowledge of the primary and secundo-primary properties of matter, and the knowledge of his own body with its parts, movements and relations, requisite for the guidance of his physical activities." (b) The *tactus eruditus* is a comparative, never a positive or absolute attainment, and our effort today shall be to compare the touch of the specialist with that of the general practitioner. A painful knowledge of his limitations is ever present with the general practitioner, unless he is lapsing into culpable indifference to the possibilities of the medicine of today. His desire for the quick, safe and pleasant recovery of his patients to the norm of health does and ought to make his easy access to the more skilled touch of the specialist peculiarly agreeable to him. His energies being taxed by the breadth of his field of labor, extending into several counties, and the length of his day of professional effort, from one to twenty-four hours; and by the variety of his tasks addressed to the welfare of human living from intra-uterine to ultra-senile, he must inevitably be aware of the superior opportunities possessed by the specialist, "whose professional life, if a laryngologist, is spent in a darkened room, his vision limited to the focal length of his reflecting mirror, and his eye confined to the illuminated spot resembling in size the gold piece which will be the reward of his skill and dexterity." (c) It is especially in diagnosing that the erudite touch is important, often revealing, during the life of the patient, what would be found by many a general practitioner only after death, at the postmortem examination, if even then. If the army of paranoiacs, neurasthenics, neurotics, atrophic, hypertrophic, degenerate mortals, the burdens of the family physician, the natural prey of mountebanks and easy slaves of narcotics, is ever to be lifted out of the slough of despond, by what other means is it to be done?

Dr. Goldspohn, of Chicago, said at the meeting in Detroit last fall: "While such knowledge is in possession of able specialists who are familiar with the opinions and experiences of most of the world's authorities and great operators, it has not penetrated through the general rank and file of honorable and efficient general practitioners, who naturally have not the time to thresh the great international stack of medical journals, society reports, etc., but are limited to the opinions of a few authorities, briefly ex-

pressed in the text-books. The text-books are the principal guide to general practitioners in matters apart from general medicine, and oftentimes in the whole domain of medicine and surgery. I am constrained to attribute much of the defects and inconsistencies in gynecology, as it is practised by general practitioners and some self-styled specialists, to the text-books, and chiefly to those of our own glorious country."

A surprisingly large proportion of good men in general practice show antipathy to the most natural and appropriate recourse to the specialist. One of our most eminent members, himself a specialist, said recently: "There has been a curious dislike on the part of physicians to calling in counsel, as if that implied a lack of knowledge on the part of the physician in charge of the case. This is certainly wrong in such a science as medicine, in which it must be evident to everyone that no man can cover the whole field, and that individual judgment may differ widely in diagnosis, which is not mathematic in its certainty. \* \* \* What may be called a diagnostic specialist is particularly valuable, in that much may be seen by a man who sees a patient for the first time, which may escape the notice of one who is seeing him every day. The help of a fresh opinion on a case, given occasionally through its course, is, I believe, a stimulus to any of us in treating long-continued cases, in treating which the patience is taxed and the mind apt to get into a rut, both as to diagnosis and treatment.

The narrowing of one's attention to a very restricted line of work has its drawbacks. \* \* \* I find myself that systematic affections, disturbances of digestion and assimilation, in fact, everything included in general medicine, are as necessary to me as the study of my own peculiar field of labor. I believe that the calling of counsel upon the standing of a general practitioner, if he selects his counsel wisely, with reference to the honor, as well as the skill of the man he calls, is always good if he deals with fairly intelligent patients; if they are not fairly intelligent, he must lose them, or his self-respect in dealing with them, sooner or later anyhow." (d)

Another of our distinguished members, after years of general practice, having taken up surgery, writes:

"I do not regret the time spent in active general work, for it has been a great educator; and yet I am making diagnoses today of cases that I had seen eight or ten years ago, and treated them for a symptomatic trouble, with but little if any permanent relief. These same cases do get well, after years of semi-invalidism, when the origin of their sufferings is discovered and treated appropriately." (e)

What is the meaning of "sixty patients a week" to a man who is expected to hunt them up in their homes, by night or day, in any condition of roads or weather, of personal weariness or illness, on his part, dosing, compounding, paying for anodynes, narcotics and anesthetics until the physician is the real patient, the actual sufferer, while the consumer of his rem-

edies is freed from suffering? Does it not mean a degree of haste too great for his best efforts and for the most satisfactory results to the patient? Does it not crowd out or render idle many worthy aspirants to a practice? Does it not tend to cheapen the value of professional services in the estimation of patient and practitioner? With faulty diagnosis and fragmentary basis for treatment, perpetuity and chronicity of invalidism are assured, or the critical moment, before which treatment would have availed, is passed. Does not "sixty patients a week" relegate to oblivion many a valuable case—history and pathologic specimen?

"The international stack of medical journals" and the endless procession of medical books must ever fail to equip the mere reader with the erudite touch. His instruction must be transferred *in succum et sanguinem*. The transient, inverted retinal image of the printed page, with the momentary mental impression, must be followed up by an humble imitation of the methods of the schools. Education through the senses is applicable to all scholars of every age. The operating room, the bedside observation carried out to its legitimate extent, the employment of living models, the cadaver work, now favored by our state law, (section 3763, Revised Statutes, enabling properly authorized medical men to procure bodies of paupers dying in infirmaries of disease not infectious, and unclaimed by friends); the vivisection of otherwise useless dogs, by which familiarity with all the details of improved or new operations is obtained; and anamnesis of the entire life of a patient who is bound to die—so that a postmortem examination not only gives the ordinary satisfaction, but reveals the presence of unsuspected disease, or clears up mysteries of ill-health in former years, until then unsolved, besides adding to the sum of our knowledge of medical and surgical landmarks, such as "McBurney's point"—all these and many other means of acquiring the *tactus cruditus* are within the reach of the general practitioner.

It was objected in the early days of the use of the clinical thermometer that too much time was required in its application to general practice to make it desirable. But he is too busy to practice medicine who cannot use it systematically. And is not the same true now with reference to many other means of diagnosis which are in use by experts?

The physical apparatus of the public schools has aided in the diagnosis of empyema of maxillary sinuses by the writer. Time would fail to tell of the numerous instances in which the writer has become indebted to specialists; and a limited and hasty inquiry among country practitioners has revealed an astonishing degree of indifference to this inestimable privilege.

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(a) Gould.

(b) Standard Dic.

(c) Dr. N. P. Dandridge.

(d) Dr. H. S. Upson.

(e) Dr. W. H. Humiston.

# Cleveland Journal of Medicine

THE OFFICIAL JOURNAL OF THE  
Cleveland Medical Society

AND OF THE UNION MEDICAL ASSOCIATION OF NORTHEASTERN OHIO

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## EDITORIAL

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### Witchery Renascent

IT is refreshing to read in the daily papers the accounts of the nineteenth-century triumphs of reason and intelligence. That the mind is everything, and that the body should be despised, is not a new idea. It has recurred with wonderful regularity for ages and has risen to the surface in particular in the last few years in the sect of self-styled Christian Scientists. The brilliant results of this system of healing do sometimes leak out, in spite of the well-known reticence of its votaries. They met with a notable illustration some days ago in the case of a child of five years of age, who died of pneumonia at the home of his parents on the West Side, without the attendance of any physician. A Mrs. Lyda Fitzpatrick had treated the boy, and in

answer to Coroner Arbuckle's questions she admitted that, although he appeared to be suffering from some affection of the lungs, she was not a physician and therefore could not tell what the trouble was.

"We do not recognize disease," said Mrs. Fitzpatrick. "We call it evil in the body or the improper thoughts that there is a power greater than that of God. When I attended the little boy the first time and spoke the truth, he improved rapidly and was soon able to be about.

"The last time he was made ill by evil I attended him at his home, but thoughts of evil were stronger than those of good and he left (died)."

"How did you treat him?" was asked.

"By speaking the truth and counteracting the effects of evil thoughts and an unbelief in the power of God," was the reply.

"And how do you speak the truth?"

"I do not examine the physical body. I examine the mind and diagnose the thought. The Bible says: 'Speak every man the truth to his neighbor.' I do not make a pretense of teaching or curing; I speak the truth, and the harmony of mind does the rest."

"Let me ask you," said the witness, "what it was that nailed Jesus to the cross?"

"I do not know," Mr Vessy was forced to admit.

"Jesus was nailed to the cross by belief in a power stronger than that of his Father. He was put in the sepulcher, and when he had risen again, that reestablished the belief in the power of God."

"Did you speak the truth to the boy and place his mind in harmony with thoughts of God's goodness?"

"No. When a person is too young to judge between right and wrong we speak the truth to the parents or those who have charge of him."

"What was the truth you spoke to his parents?"

"It was of the truth and power of God. There is only one power and that is God's goodness, which dispels and destroys the evil."

"In speaking the truth to the parents, did you think that necessary because they had wrong thoughts and those of the boy were subservient to the thoughts of the parents?"

"No, it was the general unbelief of the world, and the thought of another power that I spoke against."

"In a case of fracture what would you do?"

"Very few cases of the kind have come under my notice, but a fracture would be treated in the same way as other evils of the body."

The belief expressed in the above statement, which, to do Mrs. Fitzpatrick justice, is much clearer than are the sloppy utterances of most of the so-called Christian Scientists, shows her belief to be demonolatry, pure and simple. If, as she says, Christ was nailed to the cross, not as a voluntary matter, but because the devil, with his stronger mind and stronger will, got for a time the upper hand, it is fair to suppose that she thinks disease to be due to the same cause. There have been in past times various ways of driving out the devil. The priests of the middle ages, taking the somewhat

figurative language of the Scriptures literally, drove out devils by relics and the laying on of hands. The red Indian and the black African drive them out by tom-toms. According to Dr. Dan Millikin, some physicians who ought to know better drive them out with valerian and asafetida. Mrs. Fitzpatrick drives them out by reasoning with the patient or with his parents and friends, an exorcism which is comparatively simple but very effective, in order, although she does not say so in quite these words, to prevent him from being bewitched by their evil thoughts.

When common sense steps out the fool-killer steps in. Believers in witchcraft should have full liberty of incantations to drive out their own demons; they should not be allowed to immolate helpless infants. The Christian Science method has not the simple directness of the ordeal-bean; it is not even so sure a devil-driver as a slow fire; but it is now a little late in the century for even such mildly cabalistic arts as these, when applied to the young and the defenseless.

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### The Columbus Meeting of the State Society

THE gathering of the physicians of Ohio at the meeting of the State Society was a very notable one in many ways. The attendance was the largest of any meeting held in recent years. The papers presented were thoughtful and of a good deal of scientific value. The annual address of the President, Dr. Dan. Millikin of Hamilton, was keen and incisive, and deserved for the solidity of its thought the attention which it held by the scintillations of its wit. The part which Cleveland played in the meeting is of interest to the profession of the northern part of the State. The delegation was large, some forty physicians from this city being in attendance. The Cleveland Medical Society was elected as an auxiliary organization by a practically unanimous vote. The single dissenting voice was a very small hiss in a very large Garden of Eden. In response to our invitation Cleveland was chosen as the next meeting-place of the Society. In fact, the courtesy extended to Cleveland by other cities of the State, and the manifest warmth of our reception will leave with us a pleasant glow of satisfaction for some years to come.



THE meetings of the Ohio State Medical Society can be rendered more interesting and profitable by certain reforms in the order of business.

Some of these are suggested below with the hope that they may ultimately be adopted.

All the papers on the program should be classified into essays (extended papers) and clinical reports of cases. The former should be allowed at least 20 minutes' time for their reading and should be limited in number. The latter should receive only 10 minutes' time and a larger number of them could be accommodated.

The program should not be so crowded as to hinder discussion. The advisability of dividing into medical and surgical sections, say on Thursday and Friday mornings, should be considered.

Reports of committees, if submitted in detail, should be presented only in abstract to the general meetings, thus saving much time for the program.

The Society would profit greatly by the creation of a council or executive committee, before whom all administrative business should first come, so that it could then be presented to the Society in well-digested form.

By the adoption of some such plans as these the Society could avoid the great unpleasantness of crowding off the program numerous papers whose authors had been at much trouble to prepare for the meeting, as occurred at the last meeting at Columbus.

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IT is with great regret that the JOURNAL announces the illness of Dr. Dan Millikin of Hamilton, late President of the Ohio State Medical Society.

It is understood that Dr. Millikin has been ill with double pneumonia almost ever since the meeting at Columbus, and that his condition is such as to cause grave anxiety among his friends. As presiding officer of the State Society, Dr. Millikin made a host of friends from all parts of the state, whose sympathy will now be warmly extended to him, and whose sorrow will be keen until it is known that he has recovered. Along with his many other friends the JOURNAL extends to Dr. Millikin its sincere wishes for his speedy recovery.

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THE health division of the department of police, Dr. J. L. Hess, health officer, has just inaugurated a new form of monthly mortality report.

It was none too soon, as the old one contained names of several diseases which have long since departed from our nosology. It is admittedly

a difficult thing to devise an entirely satisfactory classification of diseases, as is seen by looking at the various modern text-books of medicine, no two of which agree in their arrangement.

With this qualification it may be pertinent to point out some apparent inconsistencies in the new schedule. Diphtheritic croup, for instance, is found under the head of fevers, and membranous croup is found under respiratory diseases, as well as ordinary croup. Aneurism and dentition are found under nervous diseases. It is astonishing to find puerperal fever under the head of diseases of the circulatory system, as are also rheumatism and syphilis. Again we find puerperal eclampsia and puerperal septicemia under the head of diseases of the generative system! With all these apparent inconsistencies the new schedule is a great improvement over the old one.

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TO our fellow-publishers and editorial sojourners:  
Take notice that the Thompson Laboratory Company of Washington, D. C., do not pay their bills. They owe us \$62.00 for advertising, and from good authority we learn that they owe larger sums to others. Those of you who have had dealings with them will no doubt be able to judge for yourselves as to their promptness in paying their bills. We feel it our duty to our brethren to make this announcement, in order that they may not be "roped in" by this alleged financially defunct company.—*Columbus Medical Journal*.

The above is self-explanatory and is especially significant when it is noted that the company above mentioned exploited a preparation called "*Pil. Orientalis*"—a proprietary preparation guaranteed to restore lost manhood and rejuvenate erectile power. It is sufficient to remark, as we did a few months since, in speaking of the Century Chemical Company of St. Louis, which was advertising stricture and impotence cures in the medical journals, and which finally repudiated its advertising bills, that, with all due respect to our esteemed Columbus contemporary, medical journals which will accept this kind of advertising and insult the intelligence and good taste of their subscribers in so doing, are deserving of small sympathy when they fail to reap any reward from the prostitution of their columns. Journals desiring the good will of the medical profession should refuse such advertisements when they are offered, and avoid all danger of financial loss as well as retain their self-respect.

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TO Messrs. Parke, Davis & Company the sincere thanks of the JOURNAL are due for many courtesies extended to its representative upon a recent visit to Detroit. The magnitude of the business of this great firm can only be appreciated after a personal inspection of their wonderful

plant, and the quality of the vast variety of products which it places upon the market can best be realized only by actual contact with the system under which their employees work. Nowhere else is the work of the great manufacturing chemist so well exemplified.

The visitor to this great establishment is freely shown all the methods of manufacture and comes away with the most wholesome respect for the quality of the products marketed by this firm. The methods of preparation (carried on under the supervision of the Japanese, Mr. Taka-Mini) of the firm's newest product, Taka-Diatase, the starch-digesting ferment, are of especial interest, as the article in question is coming into wide use. No part of the civilized world is beyond the reach of this firm, and the visitor sees goods ready for shipment to South America, to Europe, Australia and Japan. Certainly the phenomenal growth and success of this firm will be begrudged by no one who sees the care and expense taken to make every one of its products of the very highest grade.

The JOURNAL especially wishes to thank Mr. C. B. Kirtland and Mr. C. G. Carver for many courtesies received.

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THE following extract from an account of the proceedings of the Ohio State Medical Society in the *Lancet-Clinic* of June 6 are self-explanatory. The Cleveland Medical Society extends its thanks to Dr. Culbertson for his kind words, and has only to say that it proposes next May to prove itself worthy of the good impression which it left at Columbus.

Cleveland was selected as the next place of meeting. The delegation from that city was very large, and brought invitations from the local medical societies, Chamber of Commerce and Board of Trade. In the opinion of some it would have been better to have established Columbus as the regular stated place of meeting, but the Cleveland delegation came on purpose to capture the Society, and they did it, and did it in a fair, square manner. Their promises are not less than three hundred new members for the ensuing meeting, which will no doubt be made good. Everyone present felt the warm palms of Cleveland men and recognized the splendid work that is being done by the medical profession of Northern Ohio.

The medical profession of Cleveland has had a bad attack of boom bacilli. The professional thermometer indicates a condition of fever heat, but the men are nearly all young, vigorous and in splendid physical condition. They sit up late and are around so early that there is a constant wonder as to the time when sleep is indulged in, or whether they sleep at all. They walk fast, talk rapidly, and it does one good to see the way in which they move—all of which was exemplified at the Columbus meeting last week. \* \* \*

The annual dinner with the members participating as their own hosts was a marked success, and, although it is well known that the members of the Cleveland profession did have their Hollenden tavern erected for the special accommodation of their friends, it is suggested in all earnestness that the membership dinner be adhered to, and that strictly. Another suggestion

is that the Cleveland Committee of Arrangements invite the Judicial Council of the American Medical Association to be present at the ensuing meeting. In fact, it is felt that this is quite necessary, and could be made the means of convincing the council aforesaid that Cleveland is an Ohio city, and that Ohio is one of the United States in which a—well, in which the medical profession of three schools do dwell together in peace and harmony, with only the semblance of a wall of good will between its several members, and that the Code of Ethics of the American Medical Association is observed.

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### Our Toledo Letter

**T**HERE is a rumor through the state that diplomas from the old Northwestern Medical College of Toledo are being filled out and sold. The dean and secretary of the faculty were interviewed and state that the rumor is false, because the diplomas were only printed as they were needed each year. The secretary has an accurate list of all the graduates and says such a thing is impossible. Those who were members of the faculty say some malicious person is trying to injure them for some personal motive. Men who are guilty of originating such rumor cannot be weeded out of the profession too soon, because they are a disgrace to it, and place the profession in a peculiar position before the laity.

The Toledo Medical College has established a free dispensary service at the college building. This will supply a much-needed want in the curriculum of the institution, and will also increase the material for their clinics.

The Board of Police Commissioners have reduced the sanitary force one-half, claiming that they must reduce the expenses. If this is so, they should not cut down a department that is so necessary for the health and general good of the residents. If we were to have an epidemic of contagious disease in the city, what would the health department do in this crippled condition? An action like this opens the doors for those dreaded epidemics of contagious disease which make such ravages upon the population of a city. It would be more in keeping to reduce the salaries of some of the high officials, and leave the health department with more money to work with and protect the community from disease.

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**The National Medical Review**, in its June number, announces a marked change in its course. With that number it becomes the official organ of the Medical Society of the District of Columbia and will publish all the transactions of that Society. The Society adopted this plan after a careful examination of all other proposed methods of publication. The opinion was unanimous that publication in a medical journal would best serve the interests of the Society.

## OFFICIAL PROCEEDINGS

OF THE

## Cleveland Medical Society

REGULAR MEETING, May 22, 1896

*The President, DR. COOK, in the chair*

Meeting called to order at 8:15 P. M., Dr. FOSHAY acting Secretary.

A motion was carried to request our representatives in Congress to secure, if possible, the medical inspection bill as an addition to the McCall Bill which has passed the House.. Our representatives were also requested to use their influence against the passage of the bill now pending entitled, "A Bill for the Further Prevention of Cruelty to Animals in the District of Columbia."

A motion was carried to appoint a committee of three, of which committee the President of the Society shall be a member, to devise ways and means by which a city bacteriologic laboratory may be established for the preparation of our own antitoxin to be furnished to the people free of charge on the prescription of a physician.

DR. W. E. WIRT

*A Case of Lateral Curvature of the Spine*

I wish to present the case of this twelve-year-old girl to the Society this evening. She is brought to me from North Amherst, Ohio, by the family physician and gives the following history.

For some time the parents had noticed that the child was stooping considerably. She was not as mobile in the back as the other children in the family and was not playing as much as the rest. Her health was impaired, and within the last three or four months she has been complaining of considerable pain in the abdomen. The doctor told me that her back was rigid, and that she cried considerably; that at night she could not sleep well on account of the pain in the abdomen. On account of the pain, the rigidity of the spine and the deformity, I told the doctor that the case very much resembled Pott's disease. On examination I found the back very rigid, and considerably turned, yet it had more the appearance of a lateral curvature, which I so determined and named it.

Four weeks ago I took the child under my care. Cases of this kind are treated by suspension, gymnastics, massage, the using of sleeping apparatus and of the cradle, and strapping the child in the chair. When I attempted suspension I found that spasms of the abdominal muscles took place, and they were so extreme that I had to stop this exercise for a while. I felt that there was irritation of the spinal nerves and put her on bromids and other nerve-depressants and on a general tonic. At the end of five or six days the spasms having entirely disappeared I again suspended her and had no further difficulty. I regret to say that I did not take a photograph originally, but looking over a large number of photographs of curvatures of the spine I have picked these out as resembling very nearly the case.

The Whitley exercise is used at my place where I am prepared to give these special drills. A young lady carries out the exercises. In the case of this patient her pelvis is strapped to the bottom of the chair and the rest of her body is pulled well over. The curvature was very largely to the right. It was a very marked lateral curvature, and a marked posterior curvature. She was not able to correct it by voluntary effort. I would force her back more nearly straight and the spasms of the muscles and the rigidity would prevent her retaining the position. Then after the gymnastics and the suspension I have her sleep in a cradle for a time. Then she is strapped in a chair and the upper part of the chest is forced into the opposite direction. I use, at times, pressure, taking her this way. (Illustrating by placing the child's shoulder on the table, while the rest of the body is held from contact with the table, and exerting pressure downward.) I force her back over for five or ten minutes at a time. This constant attention and care that she has been getting for four weeks has practically straightened the spine. You know lateral curvature is very hard to overcome. I think you will see that she has practically a straight spine, brought about in four weeks.

I have another case of a girl about eight or nine years old that I have been treating for seven or eight weeks, with practically the same result. Bringing this about in so short a time has seemed to me very satisfactory and rather unusual. In these cases the result is obtained only by constant drill. There is not half an hour in the day that she is not forced in the right direction. When these cases are told to go home and carry out certain instructions as she had been told in the first place by the surgeon whom they had consulted, nothing is done. It is only by this constant drill and personal attention that you get these cures in cases of lateral curvature.

#### DR. LOWER

##### *Specimen showing Strength of Finger Tendons*

I have here a specimen of some interest showing the strength of the tendons. This represents the little finger of a hand caught in a shafting while trying to place a belt. The little finger was torn off and with it the tendons entire, showing muscular attachments; there was also a separation of the epiphyseal end of the first phalanx.

#### DR. MARCUS ROSENWASSER

##### *A Case of Pyonephrosis, Nephrotomy, and Nephrectomy*

In November, '95, Dr. Peskind requested me to see Mrs. B., aged 32, married six years, mother of two children, the last three months old. She had been passing pus in the urine since her marriage, occasionally some blood also. Since the birth of the last child she had been feverish and losing flesh and strength. During the two weeks preceding she had had daily chills and sweats, her temperature varying from 100 to 103 degrees. Dr. Rogers' examination of the urine was negative as to tubercle bacilli, but suspicious of gonococcus. Cystoscopic examination under chloroform disclosed almost pure pus passing from the left ureter, and clean urine from the right. She had never suffered much pain, and that little on the left side; recently there had been some pain on the right also. There was tenderness

to pressure on both sides. I advised left nephrotomy for the purpose of removing a foreign body if found and for draining the kidneys at all events.

The operation was performed at the Cleveland General Hospital November 13th, 1895. The usual oblique incision four inches long was made from the last rib downward and forward to the crest of the ilium. The kidney was large and fluctuating. After stitching it to the edges of the wound a two-inch incision was made into the posterior border, evacuating one-half pint of offensive pus. While the kidney formed a large pus-sac there was still considerable cortical substance, oozing freely. There was no stone in the pelvis as suspected. The cavity was washed with sterilized water and two rubber drainage-tubes placed and surrounded with gauze packing to control hemorrhage. Her recovery was all that one could wish. The temperature dropped immediately and the septic symptoms vanished. She passed 23 to 27 ounces of urine by the urethra, a few ounces by the wound. The pus rapidly diminished, all traces soon disappearing. She left the hospital December 24th, having gained 25 pounds of flesh, with a urinary fistula discharging a slight amount of clear urine. There was no pus in the urine passed from the bladder. Three months later the fistula had not closed and the urine again showed presence of pus. The fistula was enlarged and again drained, but without diminishing the pus in the urine. The patient began to emaciate and continued to fail so that it was decided to remove the kidney.

The operation was made on the 15th of May, one week ago. Expecting to remove a large kidney the incision did not follow the old scar but was made parallel with and over the last rib, the deeper incision in the space one inch wide between rib and chest. The kidney was so thoroughly adherent that it was found easier to remove it by peeling it out of its capsule. The substance of the kidney had shrunk so that the pelvis and dilated ureter were the larger. On account of the depth of the wound and the adhesions it was decided inadvisable to take out too much so that the pelvis was included in the ligature, forming part of the stump. Excepting the first four days during which she had mild uremic symptoms, such as drowsiness, distress in the epigastrium, nausea and vomiting, she is making a clean recovery, has a good appetite, sleeps well, and feels very cheerful. The urine still contains pus. While some of this comes from the granulating surface of the remnants of the pelvis and ureter it is possible that the other kidney may have been infected in the interval between the two operations, and that the pus is evidence of pyelitis on the right side. The cause of the dilatation of the ureter and pelvis has not been found.

### Program

DR. WILLIAM LINCOLN

#### *Complications of Purulent Otitis Media*

This paper appears in full on page 314 of this number of the JOURNAL

### Discussion

DR. SMITH

I was very much interested and instructed by this most excellent paper on the subject of complications of *otitis media*, and while I have little or nothing to add to the subject will say that I was struck by the importance of looking into these matters deeply and promptly. It seems to me that surgical interference in these cases of abscess and pus is much less dangerous to life

than the let-alone or expectant treatment. I saw a case which Dr. Leland of Boston had operated on, in which he removed the inner table of the skull, and evacuated about a tablespoonful of pus from the region of the cavernous sinus. If one should suppose that everything out of sight is all right, and trust to nature for recovery in such a case, the hopes for the patient's life would be absolutely lost; while a little, or perhaps a good deal, of nerve on the part of the operator to remove the inner table of the skull might often save a life.

I was also thinking in this connection of fractures of the base of the skull which so often extend through the temporal bone, thus letting infection reach the brain, through the ear, and perhaps causing an *otitis media* or meningitis. In such cases would it not be better to open up the mastoid process and wash out thoroughly, than to trust to the let-alone treatment?

DR. L. B. TUCKERMAN: This paper brings to my mind a case in which the advantage of thorough inspection by the city infirmary was shown. In the days when I was district physician, down on Commercial Street there was a great big darky who sent for me one day, complaining of pain in his head. I examined and found *otitis media*; I also found that he was dizzy, and when he walked, instead of being able to walk straight, he circled around, which, together with his manifest irritability, fever and the intense headache he complained of, induced me to report to the infirmary that he ought to be taken at once to the hospital and operated upon. There was no opportunity to take care of him at home. They sent their patent investigator down and he looked the man over, got him up, and as the man walked and swore a little, the investigator reported that I was mistaken; that the man was able to go to work. He died before the week was out.

DR. H. S. STRAIGHT: It is almost impossible to name in a five-minutes' discussion the various conditions which can arise as a result of a chronic suppuration of the middle ear. Any patient with suppuration of the middle ear is in constant danger of his life. The discharge ought to be stopped by all means. It may be the fault of the aurists that these cases are permitted to go from year to year, or it is just possible that the general practitioner has not taken time to instruct the people as much as he should.

The roof of the tympanic cavity, as well as the roof of the mastoid antrum is not always complete. Micro-organisms can easily travel from one space to the other and set up an inflammation. Why it is that the same kind of micro-organism, traveling from the ear, should produce an abscess of the brain in one case, sinus thrombosis in another, and a subdural abscess in another, is not well explained. It may depend upon the resistance of the tissues and anatomical features of the case. If the irritation is not very violent and the inflammation is slow and prolonged we can understand how the *dura mater* may become adherent to the periosteum of the skull, and an accumulation of pus occur underneath the *dura mater*. The symptoms vary greatly in subdural abscess, for the reason that from time to time the pus is evacuated through the roof of the tympanic cavity or roof of the mastoid cavity and for a time the patient is apparently nearly as well as ever. Then as the pus accumulates again the temperature rises and the patient suffers from intense headache in the region of the ear. When the pus accumulates the patients are apt to be drowsy, a fact which is probably explained by increase of the fluid in the ventricles of the brain and an increase of tension of



the brain. If recognized these cases can be easily managed, but it is only in recent years that they have been properly appreciated.

**DR. R. J. WENNER:** With regard to the differential diagnosis between abscess of the brain, tumor or tubercular meningitis, Strümpell, in his last work on general medicine, claims to have made a differential diagnosis by examination of the blood, showing marked polynuclear leukocytosis. In abscess of the brain or pus in any part of the body you will find peptones in the urine, and in cases of tubercular meningitis you do not. It is certainly of great importance, and would prevent a man going to the inside of the skull expecting to find pus and then finding a tumor.

**DR. W. E. BRUNER:** I have seen two cases presenting ocular symptoms, the first, when I worked in the eye-clinic in Philadelphia. The patient came with mastoid trouble on the left side. Examination with the ophthalmoscope showed an optic neuritis on the same side. The patient was operated upon with recovery. The other case was since I have been here in Cleveland; the disease had been in progress for some time. One day she came into the ear-clinic and remarked that she saw double. She was brought to the eye department and we found that she had paresis of the external rectus muscle of the corresponding eye; and an ophthalmoscopic examination showed a beginning optic neuritis of that eye, from which condition I diagnosed some intracranial trouble. The necropsy showed purulent meningitis. It is of considerable importance to see whether the eyes may show anything. At least they should be examined for they may present the first indications of some meningeal or cerebral involvement.

**DR. ROSENWASSER:** I do not feel myself competent to discuss this from the specialist's standpoint, but at the same time I have had some experience in a general way. I believe there are more of these cases of brain-abscess, or rather subdural abscess, than are diagnosed. They are very often diagnosed by the general practitioner as typhoid fever. About ten years ago I saw in Mt. Vernon, Ohio, a man who had been having such symptoms for about two weeks. He was just about in the last stages and comatose when I saw him. What struck me was the edematous condition around the back of his head. There had been no diarrhea or enlargement of the spleen. He had for many years been in the habit of consulting Dr. Turnbull of Philadelphia for a chronic discharge from the ear. My diagnosis was brain-abscess due to this ear. He died soon after I saw him and his body was brought here. At the necropsy when the skull was opened we found a large subdural abscess on the right side, with destruction, almost complete, of the petrous portion of the bone. You could take forceps and run it into the bone as into rotten wood. There was a large quantity of pus, which it was wonderful to think of in connection with the man's previous business ability. He had, until within two weeks before his death, been about, yet this disintegration must have been going on for years.

I wish to call attention to the fact that such abscesses are not always recognized, and are perhaps more frequent than we suppose.

**DR. LINCOLN:** If my paper, especially as emphasized by Dr. Rosenwasser, has aroused the attention of the Society to these troubles, so often neglected, I shall be amply repaid. To bear out what Dr. Smith says about the importance of calling in the surgeon in these cases, I would say that in Allport's series of cases, where operation was performed it was successful in

50 percent; while of the cases not operated on death occurred in each instance; we may conclude therefore that no further argument is needed as to the importance of early operation.

Dr. Straight's interesting remarks upon the occurrence of subdural hemorrhage I think are quite to the point. These collections are of comparatively frequent occurrence. Their causation is probably not different from that of the deeper-seated abscesses, that is, they occur in nearly all cases as the direct result of purulent infection from necrotic bone. Dr. Straight alludes also to the occasional incompleteness of the tympanic walls. In this connection it might be interesting to study a case reported by Kirchner, in which an abscess was found in the brain, postmortem, but no disease of the middle ear or of the mastoid was found. However a purulent condition of the inner ear existed. The cause is not even speculated upon.

I am glad Dr. Bruner called attention to the ocular symptoms. I tried to bring out that point as connected more particularly with sinus-thrombosis. It occurs also, as the doctor has very well said, in meningitis, but very rarely in pus collections.

Dr. Smith has asked in addition my belief in the matter of operating in these cases of chronic purulent *otitis media*. I would say that in the first place the thorough surgical antiseptic treatment should be given consistent trial, but when it has failed, and especially upon the first occurrence of any mastoid tenderness, operation should be undertaken and preferably by the Stacke method or one of its modifications.

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REGULAR MEETING, JUNE 12, 1896

*The President, DR. COOK, in the chair*

Meeting called to order at 8:12 P. M.

DR. J. C. WILSON, OF PHILADELPHIA

*The Treatment of Croupous Pneumonia*

This paper appears on page 303 of this number of the JOURNAL

Discussion

**THE PRESIDENT:** Dr. Wilson's very valuable paper will be left open for discussion for a few moments. We will be very glad to hear from anyone who cares to discuss the paper or wishes to ask Prof. Wilson any question in regard to it.

**DR. C. F. DUTTON:** I feel very grateful to have had the pleasure of listening to a lecture on a subject so important, and I am particularly thankful to the orator of the evening who has treated his subject so directly and comprehensively that little can be added to it by way of discussion. A point, however, was suggested in the lecture with regard to which I should like to make inquiry, that is, as to the effect of fever in weakening the heart-action. The speaker cites the experiments of Welch to show that the body may be subjected to a high temperature for many days without greatly weakening the heart. Now can a proper comparison be drawn between keeping up artificial heat and heat produced by the oxidation of the tissues of the body itself? I fully agree with the doctor in regard to heat as indicative of a toxic condition of the system. At the same time I think we should remember that there may be, and probably is, a vast difference between the heat produced in the human body by the oxidation of its own tissues and the heat that a

healthy body is able to stand by being put into a hot-air chamber; so that the fact that one can tolerate that heat and not die from it is no evidence that he may not be destroyed by his own burning up. May not, therefore, the reduction of the fever be an important factor in the treatment of pneumonia?

**DR. C. F. HOOVER:** From Dr. Wilson's discussion of the therapeutic measures demanded in pneumonia I understand that he regards the cardiac failure to be largely an affair of the right heart struggling against the increased resistance to the pulmonary arterial circulation offered by the fibrinous exudation in the alveoli of the lungs. From my own study of cases of pneumonia I am led to believe that this is not the case, but that the right heart meets its resistance in the fact that the left heart becomes unable to cope with the aortic circulation just as is the case in any other form of severe infection. When the myocardium suffers, the left heart first gives out, and secondarily the right heart fails because of the stasis in the pulmonary circulation. In support of this view I can say that I have observed the relations between the right and left heart in beginning pneumonia when the exudation was already formed and no accentuation of the second pulmonic was demonstrable, but later in the disease without any further extension of the exudation, when the left heart commenced to break down, the pulmonic accentuation was marked. In the course of two hours a case of pneumonia with extensive exudation may pass from a high temperature to a subnormal one. The struggle on the part of the heart is over; it is now working easily. The exudation is still present but the accentuation in the second pulmonic is gone.

Extensive tuberculosis of the lung may not cause an accentuation of the second pulmonic tone. Hypertrophy or dilatation of the right heart never occurs in such cases. The tension in the pulmonary artery normally is only 1-4 to 1-6 as high as in the aorta, though with each systole the pulmonary arteries receive as much blood as the aorta. The pulmonary arteries can have a large portion of their area sacrificed before accentuation occurs.

**DR. WILSON:** In reply to the first question, more attention is to be paid to our knowledge of what occurs in pneumonia itself in favorable cases, and in other diseases in which high temperature results from toxemia, than to the experimental researches that were alluded to. That is to say, we all know perfectly well that in an ordinary classical case of croupous pneumonia you have a very high temperature, running from 104 to 105½ or 106 for several days, interrupted not by decided morning remissions, but by one or two pseudo-crises; and upon the supervention of crisis as the termination of the febrile movement, the patient enters at once upon a rapid convalescence. I think this fact itself goes far to show that the mere elevation of temperature in croupous pneumonia is a thing we can afford to pay comparatively little attention to. Corroborative of that fact is the knowledge which some of us have by personal experience going back to limited outbreaks which occurred in this country toward the end of the sixties in relapsing fever. Relapsing fever is a disease in which the temperature, as in pneumonia, is high; in which the rise of temperature is extremely abrupt; in which the temperature is notably sustained for a period of five to seven days during the initial paroxysm; and in which the defervescence takes place by a very marked crisis, leaving the patient in a day or two so well that it is with difficulty he is prevented from going about and resuming his occupation. I think these examples go very far to show that mere high temperature does not require drugging.

What I plead for is to let the temperature in croupous pneumonia run its course. There is reason to suspect that it may not be entirely harmful.

With reference to the second question I intended to lay some emphasis upon a remark that I made. The habit is common, as you will see by referring to articles upon croupous pneumonia, of regarding heart failure as more common, and of attributing it to mechanical causes. I heartily agree with the second speaker that the heart failure is due not to mechanical causes, but to toxemia. Except in those cases in which we have shortly after the onset of the disease a sudden cyanosis with evidence of a struggling right heart, arising at a time prior to that at which the pulmonary circulation has been able to accommodate itself to mechanical conditions, it certainly cannot be otherwise than greatly altered from the normal.

In closing I desire to express my very high appreciation of the compliment extended to me in asking me to address you; and my deep sense of the courtesy and sympathy with which you listened to this address upon a familiar subject.

DR. A. F. HOUSE: I move that the Society tender Professor Wilson a vote of thanks for his most able and excellent paper. (Carried).

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## Union Medical Association of Northeastern Ohio

NINETY-EIGHTH QUARTERLY SESSION, HELD AT CANTON, OHIO,  
TUESDAY, JUNE 9, 1896

*The President, DR. HENRY S. UPSON, in the chair*

The meeting was unusually well attended, over 60 physicians being present. The following case was reported by DR. T. F. REED of Massillon:

*Mr. President and Gentlemen of the Society:*

In calling your attention to this case, we have more than a passing interest, as he is a personal friend of many years' standing, and a prominent business man, being closely identified with the business interests of our little city.

He is now present, and we should deem it a great favor if the Chair would appoint a committee to examine him and aid in diagnosing the nature of the disease, and outline a course of treatment.

His past history throws no light on his present condition. His history in brief is as follows: Age, 56 years. Fourteen years ago he had two accidents in one year, both resulting in injury to the chest-walls, fracturing the ribs, first on the left side, and in the second accident, those of the right side. No deformity is now apparent on either side. For the last thirty years or more he has been a great sufferer from headache, pain in the back of the neck, or, in common parlance, he has had bilious attacks or megrim, followed by more or less jaundice. This icterus is now almost constant, and has been for several years, only more apparent after one of his headaches. He has always been temperate in his eating and drinking and does not use opium

or tobacco in any form. He has had a varicose condition of all the veins for many years, being obliged to use a support to the legs, by means of bandages and elastic stockings. In examining the liver eighteen months ago, Dr. Williamson found that organ enlarged but not tender on pressure. About three weeks ago the doctor, in making another examination, detected a large mass or tumor over the region of the liver, and seemingly connected with that organ. At that time it was about three inches in diameter, painful on pressure, and felt hard and nodulated.

Since that time it has markedly increased in size, measuring three and one-half by four inches at the present time. There is no family history of cancer or malignant growth, no specific disease, and no tuberculous tendency. The urine is normal, except a trace of bile. We are at sea so far as diagnosis is concerned, and want your aid.

DR. C. F. HOOVER of Cleveland, reported in behalf of the clinical committee as follows in regard to this case: The thoracic organs are normal, the liver enlarged and nodular. The nodules are large and not sensitive, but are very hard. The spleen is enlarged and hard. There have been frequent attacks of icterus with chills. We can in this case eliminate leukemia and amyloid disease. Whether syphilis is present remains in doubt; it is quite possible. The main problem is whether this is cirrhosis of the liver; the indications are against portal cirrhosis and in favor of biliary cirrhosis. Tumor cannot be eliminated with certainty.

DR. S. J. WRIGHT of Tallmadge delivered a lecture on the "Erudite Touch." This paper appears elsewhere in the JOURNAL.

DR. J. H. SEILER of Akron, read an interesting essay on "The Doctor and His Relation to the Community."

DR. H. B. BLANKENHORN of Orrville, read an essay on "The Influence of the Kidneys and Heart in the Surgeon's Work." He emphasized especially the necessity of a very careful examination of the urine and the heart before using an anesthetic, and varying the anesthetic used in operative procedure in order to spare any organ which has been found diseased. The essay was a very careful presentation of an important subject.

#### Discussion of Dr. Blankenhorn's Paper

DR. EVERHARD of Wadsworth, is in the habit of using chloroform in most of his cases. He disagreed from the lecturer in his statement that a mistake is made in using only one anesthetic. He thinks on the whole chloroform is not more dangerous to the heart than ether, and there are fewer bad after-effects, and that it has great advantages over ether.

DR. TRESSEL, of Alliance: The difficulty is that there are so many cases in which, if time were taken for an examination, the patient would be in the "happy hunting ground." Effective antisepsis is absolutely essential to a successful operation. Good elimination by the kidneys and skin is desirable, but operation is often necessary whether these are present or not. Are we to avoid operation on people with diseased heart or kidneys on this account?

DR. BRANNAN, of Canal Dover, had had two cases in which he had given chloroform. One case, in which laparotomy was performed, was desperate; the heart action was rapid and irregular before anesthesia was begun.

The moment she came under the influence of chloroform the heart-beat became regular and slow; when she came out it became irregular again. In the other case he gave chloroform for the extraction of a tooth. There was a valvular heart-disease. She took the chloroform well and made a good recovery. He knows of no signs by which we can tell definitely whether a patient will take an anesthetic well or ill.

**DR. W. MCKEAN** sat under the teaching of Professor Gross, who used chloroform to the exclusion of ether. He had always had a preference for chloroform and found it satisfactory. He cited one case in which chloroform was given for excision of the breast. The patient took the anesthetic well but died two months afterward of heart failure.

**DRS. T. W. JACKSON, H. S. STRAIGHT, M. M. BAUER and A. B. WALKER** presented written reports of cases. These papers will appear in future issues of the JOURNAL.

### **Discussion of Dr. Walker's Case of Intubation for Membranous Croup**

**DR. EVERHARD** raised the question if this was diphtheria. **Dr. Hal. Jacobs** had intubated several cases for him but all had died on the third day after the operation, although for a time they were apparently much improved except one case, which was not diphtheritic. He then began to use antitoxin with the most gratifying results. He thinks the tube stimulates absorption of the toxin and septic poisoning is set up.

**DR. MCKEAN**, of Dundee, described a case which occurred in his own family. The little boy at first had apparently taken cold. He had fever but no glandular swelling at first, but within a few days an exudate appeared, having the characteristics of true croup. There were cases of diphtheria in the neighborhood. The patient made a perfectly good recovery. **Dr. McKean** now urges on parents the importance of intubation.

**DR. T. H. BRANNAN**, of Canal Dover, has found intubation very satisfactory. When the patient dies the operation is justified by the comfort it gives and the amelioration of the symptoms. In one case in which the tube was removed after a week the patient became as cyanotic as before. He was again intubated and the tube was left for another week. He then made a good recovery.

**DR. WALKER**, in closing, says he believes his case was not diphtheria, but simple membranous croup. If it had been diphtheria the patient would have died of sepsis. He never has seen a case of recovery after intubation in true diphtheria. According to the observations made by the New York Board of Health in cases of laryngeal diphtheria, 50 percent show the bacillus; of cases reported as membranous croup, bacilli are found in over 80 percent. He has seen cases of croup start diphtheria in a family. Membranous croup is likely to prove fatal early. There is, as regards sanitary reasons, practically no difference between these two troubles. Glandular enlargements are not necessarily set up in laryngeal diphtheria.

**DR. JAMES FRAUNFELTER** read a very interesting paper on "Puerperal Infection, Its Causes and Treatment." He showed very clearly that such infection was usually the result of carelessness on the part of the attending physician, or of the nurse or the patient herself, and that it can be prevented by rigid attention to cleanliness and the use of proper antiseptic substances.

### Discussion of Dr. Fraunfelter's Paper

DR. A. M. SHERMAN thought an antiseptic not at all essential. He said these measures were not carried out 40 years ago nor 4,000, and babies have gone on being born all the time. It looks all very well in theory, but, gentlemen, do you do it in practice? Do you stop to wash your hands in bichlorid while a woman is crying to you for help?

DR. MCKEAN: The question is, if a man would be justified in the courts of law, if he went from a case of diphtheria, scarlet fever or puerperal fever to a confinement case and the patient developed puerperal fever.

DR. FRAUNFELTER, in closing the discussion, said that he was very glad to elicit the different views which had been given, and reiterated his belief in cleanliness and antiseptics.

It was decided to hold at Alliance, in September, a joint meeting with the Medical Association of Eastern Ohio and the Union Medical Association of Columbiana and adjoining counties. At this meeting the following program is announced on the part of this Society: Essay, DR. N. S. EVERHARD; Lecture, DR. C. F. HOOVER; Reports of Cases, DRs. HAL JACOBS, W. E. BRUNER, T. M. SABIN.

The regular August meeting of the Society will be held at Akron. The following program is announced: Essays, DRs. W. C. STEELE and E. O. PORTMAN; Lecture, Dr. C. E. NORRIS; Reports of Cases, DRs. R. H. BARNES, J. A. DICKSON, C. S. HIDDLESON, J. F. MARCHAND, T. H. BRANNAN, C. A. HAMANN, E. O. MORROW; Discussion: DRs. W. MCKEAN and A. K. FOUSER.

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**The Region of the Great Lakes.**—For those patients living far inland, who need a moist, cool and equable climate and with whom the long and expensive journey to the seacoast is not to be considered, there is fortunately in this country a happy alternative. The vast bodies of fresh water constituting our "Great Lakes" supply these close at hand with a seashore climate and seashore life, the importance of which can hardly be overestimated. Although differing in some particulars, it may be said that the climate of the Great Lakes in summer resembles closely that of a seashore. There is the same high proportion of moisture in the air, the same coolness, the same increase of ozone, and the same comparative freedom from dust particles and from bacteria. The chief difference lies in the somewhat lessened equability, since, although the Great Lakes are much less subject to sudden and extreme changes of temperature than are inland regions, they still possess hardly so equable and even a climate as does the seacoast. They supply, moreover, all the water sports and diversions that make seashore life in summer so attractive.

The thousands of miles of coast line of these lakes are thronged with summer resorts of all sorts, big and little, fashionable and primitive. We can only attempt in these pages to mention some of the better known ones, but one of the great advantages of this region is that it abounds in quiet, unpretentious but comfortable resorts where, at very moderate expense, patients can obtain a summer outing and lay by a store of strength and vitality by living the unconventional, healthful, out-of-door life of the lakeshore.

## Medical News

**The Michigan State Medical Society** met at Mt. Clemens June 4 and 5.

**The new Lakeside Hospital** will not be ready for opening until January 1st next.

**Dr. John Lynn Carter** died June 12 at the residence of his uncle, Dr. I. N. Oakes, at Ridgeville, this State.

**Dr. E. J. Cutler**, of this city, had \$180 worth of jewelry and laces stolen from his residence at 270 Franklin Avenue, June 7.

**Dr. Otto Landman**, of Toledo, goes to Europe in July to pursue studies in neurology as bearing upon ophthalmology.

**Dr. H. W. Rogers** by invitation read a paper upon heart disease before the Portage County Medical Society at Ravenna on Thursday, June 4.

**Dr. W. H. Humiston** and Dr. P. M. Foshay attended by invitation the meeting of the Ontario Medical Association in Windsor June 3.

**Dr. E. G. Carpenter** examined Romulus Cotell in his cell in the Akron jail June 9, with especial reference to the sanity of the murderer.

**Six of the most prominent** young homeopathic physicians in this city have matriculated for the final year's course at one of the regular medical colleges of Cleveland.

**Dr. Henry S. Upson** was in Philadelphia June 2 to 4 inclusive attending the meetings of the American Neurological Association, of which he was elected second vice-president.

**Dr. Thad. A. Reamy** has resigned as a member of the Gynecological Staff of the Cincinnati Hospital, after many years' service. Dr. C. A. L. Reed has been elected to the vacancy.

**Dr. C. F. Grant**, of Minneapolis, has taken the office of the late Dr. Albert Hoover, of Akron, and will devote himself to the same special work as his predecessor, *i. e.*, eye, ear, nose and throat diseases.

**The Western Medical Review** is a new medical monthly published at Lincoln, Neb. It is a clean-looking, high-class journal, and it deserves success if conducted along the lines indicated by its initial number.

**Dr. J. P. Armour**, of St. Catherines, Ont., was in the city June 4 on his way home from the meeting of the Ontario Medical Association at Windsor. He also visited friends and relatives in Ashtabula County.

**Dr. Obed Yost** has left the city and settled in Avon, where he succeeds Dr. Randall who has been compelled to retire from practice by reason of a severe injury to his right hand.

**A great effort** is being made by the friends of St. Alexis Hospital to raise funds for needed improvements and additions to the plant. It is hoped the endeavors will meet with the success they deserve.



**A garden party** for the benefit of St. Vincent's Charity Hospital was given upon the hospital grounds on the evenings of June 17, 18 and 19. It is understood that the effort has been very successful.

**The old-established** firm of R. Parsons, Son & Company has been merged into The Parsons Company, and the new concern with increased capital is erecting a six-story manufacturing block, with store rooms, upon Erie Street.

**About 7,000 physicians** have now registered with the new State Board of Registration and Examination. At \$5.00 a head the Board has received \$35,000, but the newspapers state that on June 4 the Board paid into the State Treasury \$10,000, which, with \$5,000 previously paid in, made \$15,000 in all to that date.

**Dr. William Sisler**, of Akron, died June 8 of paralysis in his seventy-seventh year. He had practiced medicine 50 years. He had also served at different times as County Commissioner, Representative in the Ohio General Assembly, and Trustee of the Children's Home.

**Dr. Willard Parker**, of New York, son of the founder of the famous Willard Parker Hospital, has been forced to make an assignment. The unfortunate step is said to be due to Dr. Parker's too ready generosity to needy friends and the poor in general.

**The Marine Hospital** in this city, having been entirely relinquished to the United States Government on April 1 by the Lakeside Hospital Association, is now undergoing a thorough renovation under the efficient direction of the surgeon in charge, Dr. R. M. Woodward.

**Dr. G. N. Stewart**, Professor of Physiology in the Western Reserve Medical College of Cleveland, Ohio, will spend the summer in Scotland. Dr. Stewart while abroad will write for us the paper on "How to Teach Physiology," which we will publish in the symposium on "How to Teach Medicine."—*Medical Fortnightly*

**The Annual Meeting** of the Northern Ohio District Medical Society will be held at Sandusky July 16. The election of officers for the ensuing year will occur at this meeting and an amendment to the Constitution proposing semi-annual instead of quarterly meetings will be voted on. Sandusky is a charming place for a summer meeting and a large attendance is assured.

**The Local Committee** of Arrangements for the 1897 meeting of the Ohio State Medical Society held its first meeting at the Hollenden Hotel June 5. Organization was effected by the election of Dr. W. H. Humiston as Chairman, Dr. J. F. Hobson as Secretary, and Dr. A. R. Baker as Treasurer. The following appointments of chairmen of various subcommittees

were made: Committee on Entertainment, Dr. J. E. Cook; Committee on Finance and Exhibits, Dr. A. F. House; Committee on Publication and Printing, Dr. A. R. Baker.

**Dr. F. E. Bunts** will return from his European trip the first week in July.

**Dr. William Thomas Corlett** sails for England, July 19. He goes to attend the International Dermatological Congress at London and will present a paper to this meeting of the world's dermatologists.

**The leading accident** insurance companies have increased the premium paid by physicians 20 percent by reason of alleged extra hazard from blood-poisoning. They report accidents of this sort as of very frequent occurrence for the last few years.

**The American Medical Review** has profited by the change in management and the June number is a very creditable one. This publication is rapidly winning an established place among American physicians.

**A new proprietary** remedy called Ammonol, said to be the latest discovered coal-tar product is stated to be a mechanical admixture of acetanilid 6 parts, ammonium carbonate  $1\frac{1}{2}$  parts, sodium bicarbonate 3 parts and enough methyl orange and curcumin to give the color. It masquerades as Ammoniated Phenylacetamide (ammoniated acetanilid) and the formula is given as  $C^6H^5NH^2$ , *i. e.* anilin oil!

**The Ontario Medical Association** held its sixteenth annual meeting at Windsor June 3 and 4. The location was an experiment, as previous meetings have been held in Toronto. The meeting was not large but it was enthusiastic and the papers and discussions were very interesting. Great credit is due the half-dozen physicians of Windsor for their self-sacrificing and successful efforts to make the meeting a good one. The business of the Association is greatly expedited by its division into medical and surgical sections at certain times.

**Some interest** attached to the trial before Director of Fire Department Hechler of Dr. D. L. Travis, Surgeon to the Fire Department, on the charge of professional neglect. It was alleged that a member of the department came to him with signs of typhoid, received a prescription but was not ordered to bed. The patient died, the fatal result being alleged to be due to the neglect of the surgeon. A number of prominent physicians of the city gave testimony tending to show that Dr. Travis did only what most physicians would do under the circumstances. Dr. Travis was entirely exonerated.

**The regular quarterly meeting** of the State Board of Health was held at the Hollenden Hotel, this city, June 17 and 18. The usual amount of routine business was transacted. The Secretary, Dr. C. O. Probst, in his quarterly report recommended that all the local health boards in the State

make the tuberculin-test on the cows of the State. A petition was received from the Mayor of Elyria asking permission for his city to go to Lake Erie for its water-supply. Those present at the meeting were: Dr. S. P. Wise, of Millersburg, president; Dr. William T. Miller, Cleveland, vice-president; Dr. Thomas C. Hoover, Columbus; Dr. R. D. Kahle, Lima; Dr. Brayton Stanton, Cincinnati; Josiah Hartzell, Canton; Professor E. T. Nelson, Delaware; and Dr. C. O. Probst, secretary, Columbus.

**The sixty-first** quarterly meeting of the North Central Ohio Medical Society was held at Mansfield June 26. The program included the following papers: "Malignant Neoplasms," by R. Harvey Reed, M. D., Columbus; "Serum-Therapy," by George M. Waters, M. D., Columbus; "Retention of Urine, its Causes and Surgical Treatment," by C. B. Parker, M. D., Cleveland; "What Should be Observed in the Incipency of Acute Eye Inflammation," by J. W. Wright, M. D., Columbus; "Luxation in the New-born Infant," by Harry B. Bertollette, M. D., Shreve; Diseases of Bones," an illustrated lecture, by George W. Crile, M. D., Cleveland.

**Dr. John Aulde**, has resigned the editorship of *The American Therapist* and relinquished his interest in the same, although he was really its founder and has been the editor from the first number to the present (No. 10 of Volume IV).

**Dr. John Whitridge Williams** has just been appointed professor of obstetrics at the Johns-Hopkins University, and is in full charge of the department. He was formerly associate. This is not only a great honor for such a young man, but a distinction of being the only native Baltimorean among the professors of that university.—*Medical Fortnightly*.

**There has** been established in Amsterdam, under the editorship of Dr. F. H. A. Peypers, a journal devoted to the history and geography of medicine.—*Science*.

**The Rebman Publishing Company**, London, has in press a serial entitled *Archives of Clinical Skiagraphy*, edited by Dr. Sidney Rowland. The first plate will be the osseous system of a child, and five further plates, showing obscure injuries to the knee, etc., will be included in the first part.—*Science*.

**The Canton Medical Club** held its third semi-annual social session at the Hurford House Monday evening, June 8. The program was opened by Hon. Henry W. Brant, an attorney of Chicago, who discussed the medico-legal expert witness. Dr. Henry S. Upson, of Cleveland, read a paper upon the causes of nervousness. Prosecuting Attorney C. C. Bow addressed the Club upon "The Relation of Hypnotism to Crime." Dr. Grant Mitchell spoke of dentistry and its relation to systemic disease.

Following this program the Club and its guests sat down to a banquet where Dr. A. B. Walker presided as toastmaster. The following is the pro-

gram of toasts: "Our Club Address," Dr. C. H. Evans; "The Ethical Physician," Dr. Henry S. Upson; "The Doctor in Politics," Dr. A. C. Brant; "The Relation of Dentistry to Medicine," Dr. Grant Mitchell; "The Relation of Law to Medicine," Hon. Henry W. Brant; "The New Medical Law," Dr. X. C. Scott; "The Doctor as a Witness," Attorney C. C. Bow.

**A Pugilistic Physician.**—Medicine with its many drawbacks is after all preferable to prizefighting, and we advise Dr. Payne, of Ohio, to stick to it; that is, if he is, as we have been informed, a real doctor of the practising kind. In an attempt to win pugilistic laurels from Boston's "Dick" O'Brien before the Eureka Athletic Club on April 6th, the latter gentleman is said to have administered what he is pleased to call his Payne killer with such prompt effect that the physician did not require a second dose.—*Medical Record*.

**The Medical Record** of June 13 devoted a large amount of space to summer health-resorts and in honor of the occasion decked itself out in a blue cover and greatly increased number of pages. Its remarks concerning the climate of the Great Lakes are of interest to the profession of this part of the country, and will be found on page 346 of this number of the JOURNAL.

**Dr. C. F. Hoover** will deliver a lecture to the Portage County Medical Society at Ravenna on Thursday July 2.

**Dr. Snow** of Garrettsville, attended the June 26 meeting of the Cleveland Medical Society.

**The bicycle** is proving of great use to the medical profession. In many cases the sick can be thankful that the doctor has a bicycle and can thus be at the bedside in less time than that required for harnessing a horse.

—*Scientific American*

**Accidental Injuries.**—An analysis of 2,000 accident policies on which benefits were paid shows 531 persons injured by falls on pavements, 243 by carriages or wagons, 75 by horse kicks or bites, and 47 by horse-back riding; 117 were cut with edged tools or glass, 96 were hurt by having weights fall on them, and 72 were hurt in bicycle accidents, while 72 were hurt by falling down stairs.—*Medical Record*

### The Mississippi Valley Medical Association

A meeting of the Executive Committee of the Mississippi Valley Medical Association was held at Atlanta on May 6th, and the following gentlemen were appointed to deliver addresses: Dr. H. N. Moyer, Chicago, Address on Medicine; Dr. Horace H. Grant, Louisville, Address on Surgery. The indications are that the meeting to be held at St. Paul on October 20, 21, 22 and 23, will be the largest and most successful in the history of the Association. As all the railroads will offer reduced rates for the round trip, an opportunity will be given to visit St. Paul and Minnesota during the most delightful season of the year.

### Medical Men to Avoid

The one who has acute exacerbations of insanity when exposed to any new fad. The one who is always successful with his difficult operations. The one who always sees hundreds of cases of a rare disease. The one who can always match your case and improve on your treatment. The one who always says you have omitted something in the examination of your case. The one who thinks he can talk well and is always ready to discuss any paper of the evening. The one who is always first to do the new operation. The one who is in a chronic fear of being anticipated in his important discoveries. The one who in consultation feels it his conscientious duty to explain to the patient why he differs with the attending physician.—*Medical Record*

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The *New York State Medical Reporter* for May contains a symposium upon the external treatment of croupous pneumonia. Cleveland is represented by replies from Dr. E. J. Merrick, Dr. H. H. Powell, Dr. H. J. Herrick, and Dr. Frank Kraft. The remarks of Dr. Dan Millikin, of Hamilton, late President of the Ohio State Medical Society and Professor of Medical Jurisprudence in the Miami Medical College, are so excellent as to be well worthy of reproduction in the *Journal*.

In response to a recent letter received from you, I have to say, in brief, that I regard all outward applications to the chest in cases of pneumonia as an impertinence. It has always seemed to me that the applications are really very remote from the seat of the disease, and I could never yet bring myself to the belief that an application, hot or cold, irritant or nonirritant, could impress the lungs which have no direct vascular or nervous connection with the integuments of the thorax.

Looking upon pneumonia as one of the acute infectious diseases, threatening life most commonly by depression of the nervous system through the development of toxins, and especially depressing the nerve-apparatus of the heart, I have found something else to do with my patients rather than to oppress them with weighty applications to the chest.

I can say further, that cold applications will be very disagreeable to more than one-half of the patients suffering from pneumonia, and hot applications will be directly detrimental to another large fraction of cases which suffer from high temperature. I will say yet further, that most outward applications are survivals of savage therapeutics which seeks to drive out a demon or a half-personified morbid principle. I have outgrown that sort of practice and I wish that my race had done so.

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Ominous for the future of Philadelphia as a medical center is the utter indifference to its representative organizations manifested by the local profession. The *Reporter* has suggested a fundamental cause for this indifference in the lack of foresight and of ordinary enterprise on the part of the organizations themselves, as demonstrated by the neglect to acquire or even to encourage the simplest but most powerful of all engines of progress—

a press distinctively representative, not in the form of mausolean archives, such as are provided in the "transactions" annually published by the societies—but in the form of popular periodicals which will keep current work constantly in evidence, and thus maintain and enhance the interest at home and abroad. *Medical newspapers*, if you please. Avenues for constant communication between living men, considering living ideas and dealing with living issues. In fact, journals such as represent all progressive communities with aspirations for the advancement of the science of medicine.—*Medical and Surgical Reporter*

### Medical Libraries

James R. Chadwick, M. D., Librarian of the Boston Medical Library Association, says:

In the early years of practice, few men can afford to buy or even give shelf-room to a tenth part of the books that they need; no man, whatever his means, can possibly acquire all. A library is consequently indispensable in every center of population, or the health and lives of the community will be jeopardized by the ignorance of its medical practitioners. Could this fact be realized by the liberal men of means in our midst, self-protection, if no higher motive, would stimulate them to endow our medical libraries with as free a hand as they now evince toward hospitals. The benefits conferred upon suffering humanity would be greater, though less manifest to the ordinary man of wealth. \* \* \* I have sought by the analysis of these curves to indicate the principal factors in the growth of a medical library. The lessons to be drawn from this enumeration are that if a valuable collection of books is accumulated the profession will rally to supply for it a suitable abode, and, as my friend, Oliver Herford, says, "It's a poor pill that will not work both ways," so we find that if a fine building is erected the library will soon be forthcoming. In either and every case some one man must work early and late to secure contributions and especially to make complete the files of periodicals.

I would not be understood as intimating that money is not needed for the building up of a library. As the Chinese say, "With money you can move the gods; without it you cannot move a man." Money and much money is needed for the maintenance of a library. The continuous service of a librarian and perhaps one or two assistants must be paid for. Many hundred volumes must be bound every year. A certain number of periodicals must be secured for your reading-rooms as soon as published and therefore by subscription. The list of these may be supplemented immensely by securing gratuitously the exchanges of your medical journals, the journals received by your instrument maker and manufacturing chemist, etc., in return for their advertisements, the journals circulated in journal clubs of medical men after they have gone the rounds. You may also obtain in exchange for your own transactions the publications of nearly all kinds of societies.

Finally, an author, subject and title card-catalog must be kept up to date, no matter what the expense. "Who wants a lock without a key, a ship without a rudder, a binnacle without a compass, a check without a signature, a greenback without a goldback behind it?" (O. W. Holmes.)

- *Maryland Medical Journal*

## Condensed Table of Mortality in Cleveland for May, 1896

By courtesy of Dr. J. L. Hess, Health Officer

<b>I.—FEVERS.</b>				<b>Hepatitis</b> .....	1
Influenza.....	1			Acute yellow atrophy.....	1
Typhoid.....	14			Abscess of liver.....	2
Diphtheria.....	9			Cirrhosis of liver.....	2
Varicella.....	1				
Intermittent fever.....	1			<b>V.—DISEASES OF CIRCULATORY SYSTEM.</b>	45
Erysipelas.....	1			Dilatation of heart.....	4
	27			Fatty degeneration of heart.....	1
<b>II.—DISEASES OF THE NERVOUS SYSTEM.</b>				Rupture of heart.....	1
Marasmus.....	8			Endocarditis.....	7
Meningitis.....	22			Myocarditis.....	2
Softening of brain.....	3			Valvular disease.....	6
Abscess of brain.....	2			Aneurism.....	1
Apoplexy.....	4			Anemia.....	2
Epilepsy.....	2			Pyemia.....	1
Tumor of brain.....	1			Septicemia.....	5
Sclerosis of brain.....	1			Puerperal fever.....	1
Tetanus.....	2			Rheumatism.....	7
Cerebral embolism.....	4			Rickets.....	1
Convulsions.....	32			Syphilis.....	2
	81				
<b>III.—DISEASES OF RESPIRATORY SYSTEM.</b>				<b>VI.—URINARY DISEASES.</b>	41
Croup.....	1			Nephritis.....	8
Croup—membranous.....	1			Acute Bright's disease.....	1
Bronchitis.....	6			Chronic Bright's disease.....	1
Phthisis.....	16			Cystitis.....	1
Pneumonia.....	36				
Pleurisy.....	2			<b>VII.—GENERATIVE SYSTEM.</b>	11
Congestion of the lungs.....	2			Postpartum hemorrhage.....	1
Edema of the lungs.....	1			Cancer of breast.....	2
Gangrene of the lungs.....	1			Cancer of uterus.....	1
Tuberculosis.....	14				
Cancer.....	4			<b>VIII.—VIOLENT CAUSES.</b>	4
Asthma.....	3			Accident.....	4
Whooping cough.....	3			Suicide by hanging.....	3
	90			Suicide by shooting.....	2
<b>IV.—DISEASES OF THE DIGESTIVE SYSTEM.</b>				Homicide.....	2
Strangulated hernia.....	1			Burns or scalds.....	1
Gallstone.....	1			Railroad injuries.....	3
Gastritis.....	2			Shock.....	2
Cancer of liver.....	1				
Cancer of stomach.....	2			<b>IX.—UNCLASSIFIED.</b>	17
Enteritis.....	1			Premature birth.....	13
Peritonitis.....	14			Senile debility.....	2
Obstruction of intestines.....	2				18
Diarrhea.....	3				33
Cholera Infantum.....	8				
Enterocolitis.....	3				
Jaundice.....	1				

Total deaths for May, 349. Total deaths for May, 1895, 371.

Annual death-rate per 1000 during the month (estimated population 330,279) 12.44+

## BUSINESS DEPARTMENT CLEVELAND JOURNAL OF MEDICINE

P. MAXWELL FOSHAY, M. D., BUSINESS MANAGER

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Short notes upon clinical experiences or reports of interesting cases will be welcomed by the editors.

Original articles are accepted for publication by this JOURNAL only with the distinct understanding that they are contributed solely to this JOURNAL and will not be published elsewhere as original.

# Cleveland Journal of Medicine

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No. 8

## An Original Method of Using Dry Heat of High Temperature in the Treatment of Chronic Joint Affections

BY WILLIAM E. WIRT, A. M., M. D., PH. D., CLEVELAND

*Professor of Orthopedic Surgery in the Cleveland College of Physicians and Surgeons*

LAST October I presented to the Mississippi Valley Medical Association an informal report of the use of dry heat of high temperature in the treatment of chronic joint affections. I had at that time been using this method of treatment for about one year. Notice of this informal report was given in several of the medical journals throughout the United States. As a result of this informal report I received during the past year a number of letters asking me to direct the writers to a full report of my method of using the heat. These letters I answered in person, but as no full report had been made it required in each case that a complete description be made of my apparatus. That my article had attracted some little attention seemed to me reason enough for my presenting at this time a full description of the apparatus I am using.

Medical writings indicate that heat and cold have been used for many ages to allay all forms of inflammation. The effect of these agents is determined firstly by their influence in modifying the circulation of the blood, secondly by their power to increase the activity of the lymphatic circulation, thirdly by their modification of the secretion, and fourthly in certain instances by the apparent influence on the nerve-supply to a part.

In the effort to allay inflammation by heat this agent has been used of nearly every range of the thermometer, from that of the blood to that of the

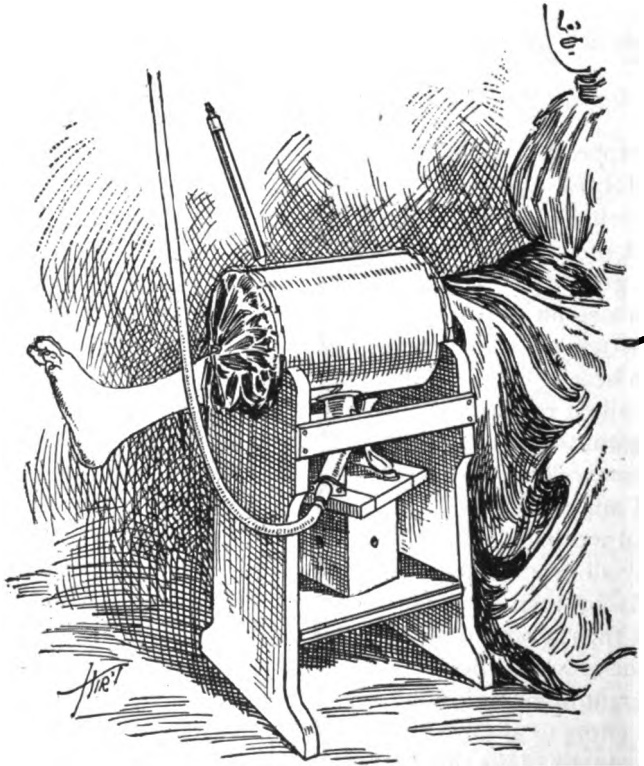
*Read before the Cleveland Medical Society, June 26, 1896*



white heat of the Paquelin cautery. The low temperatures are applied for prolonged periods, ofttime while the higher temperatures are used only momentarily.

The method I am describing contemplates the *prolonged use* of a high temperature, say 250 to 300 degrees F. for a period of one-half to one and one-half hours. While the prolonged use of low temperatures and the momentary use of high temperatures each modify the circulation, and the latter probably the nerve-supply, they neither of them markedly influence the secretions, and but little, if any, do they increase the lymphatic circulation.

On the other hand, the prolonged use of high temperatures, while in a like manner it influences the blood and nerve-supply, it in addition enormously increases the secretions; and further, it is my belief (though I am not able to demonstrate it) that the lymphatic circulation is enormously increased, thereby rapidly taking up in its circulation the deposits which have taken place in the diseased joint, which in a measure accounts for the greater freedom of motion noticeable in these joints after the prolonged use of high temperature.



Apparatus for using dry heat of high temperature in the treatment of chronic joint affections.  
(The foot should have been on a chair of the proper height.)

Physics and physiology teach us that while the body can only bear a temperature of about 160° degrees in a saturated atmosphere, yet if the air is kept very dry the body can stand a temperature of several hundred degrees F. for part or even a whole hour. To give exact data it is stated that a man has endured for half an hour a temperature of over 600 degrees F. in a drying oven.

The apparatus before you, which, by the way, I have had made for a Boston surgeon, consists of a copper cylinder  $12\frac{1}{2}$  inches long and 10 inches in diameter. Fitting into each end of the cylinder is a wooden ring or disc one inch wide by one inch thick. The wooden rings are secured in the ends of the cylinder by eight short screws passing from the outside through the cylinder into the rings. At each end of the cylinder is a hood which encircles the limb, and is drawn tight by means of puckering strings. The hood is made of double coated rubber cloth, and is attached to the cylinder by being nailed to the wooden rings, the extreme end of the hood being held in place by a wire band. On each side of the cylinder diametrically opposed are two or three holes  $\frac{1}{2}$  inch in diameter. The purpose of these holes is to allow a rapid change of air in the cylinder. In using these cylinders I have seen the air come out of these holes with such force as to put out a lighted match. The cylinder is supported horizontally in a wooden frame so that the lower surface of the cylinder is 18 inches from the floor, or about the height of an average chair.

I have applied heat by means of oil, gasoline, or alcohol lamp, the gas jet, and the mixed gas and air jet, which is the Bunsen flame; the latter is probably the most convenient. The heat should not be turned on too rapidly at first, as the patient's endurance is greater if the heat is applied gradually.

In using this method for the knee I apply a layer of cotton to the back of the limb in the popliteal region, securing it in place by loosely-tied tapes. This is done for two reasons: in the first place it will equalize the temperature, as undoubtedly the lower part of the cylinder is much hotter than the upper, and secondly I found that the profuse perspiration, resulting from the high temperature, caused a dropping of fluid to the bottom of the cylinder, where it was instantly turned into steam, and this steam would immediately scald the limb.

The limb, being thus protected by the cotton, is inserted into the cylinder until the knee is in the center, the heel placed on a chair high enough to keep the calf from touching, if possible, even the wooden rings, which though they do not ordinarily burn, yet they may get uncomfortably warm. The hoods are drawn tightly around the limb, and at the start rubber corks are inserted in the holes in the cylinder, but are withdrawn when the cylinder is thoroughly heated. The heat is then applied to the cylinder and is carried up to the limit of endurance of the patient, which varies from 250 to 300 degrees,

and is kept at this point for an hour or more. One patient of mine could stand a temperature of 290 degrees for over an hour. In a case I recently treated I carried the temperature to the extreme point of 360 degrees F. for a period of nearly five minutes.

The thermometer I use is a laboratory thermometer with a scale that will register up to 450 degrees F. I have found it most satisfactory to allow the patient to hold one end of the thermometer, while the bulb end is held within the cylinder along side the knee against the cotton. Care should be taken not to touch the limb with the thermometer, for if this happens the limb will be blistered; this can easily be prevented by the proper use of the cotton.

The number and size of the holes in this cylinder is not sufficient to give perfect ventilation, so that after twenty or more minutes the air in the cylinder becomes so moist from the profuse perspiration that I find it advantageous to loosen the hoods for about a minutes at a time to allow a free exchange of air. This lowers the temperature 20 or 30 degrees, but the cylinder is so hot that it quickly returns to its former range.

The effect of such high temperature is to enormously increase the perspiration from the local part, to increase perspiration over at least the surface circulation, to increase the lymphatic circulation, to relieve pain, and to increase motility in the joint. The relief of pain and the increased motility last for some hours after the application of the heat.

To make it a little plainer what these effects are I will go somewhat into detail. In regard to the perspiration of the local part I would say that it is so great that if not absorbed by the under layer of cotton it will roll off rapidly in drops, and the whole amount evaporated in an hour must be considerable. The circulation of the blood is also greatly increased, and is very apparent on the surface, the part being reddened and the arterioles dilated as is seen in the blush of an erysipelas. The pain and stiffness are greatly relieved. Take, for instance, an old case of gonorrheal rheumatism, or rheumatoid arthritis, and we will find that at all times there is more or less pain with considerable stiffness, and the motions of the joint are accompanied with creaking sounds. At times there are exacerbations when all these symptoms are considerably increased. It has been my experience in the use of this apparatus that very soon after the temperature in the cylinder is raised to 250 degrees the patient feels entirely relieved of the pain, and on removing the limb from the apparatus after the treatment it is found that the motility of the joint is considerably increased, and the creaking sounds have greatly diminished, or entirely disappeared. The marked effect of the heat is especially noticeable at the time of an exacerbation, when the difference in the condition of the joint before and after the treatment is considerable.

To give you an idea of how hot the inside of the cylinder becomes I would state that the cotton covering the popliteal space becomes burnt to a

brown, and the index of the thermometer, which is of paper and inside the glass tube, also becomes singed to a brown color. I have used the apparatus in cases of simple rheumatism, rheumatoid arthritis, gonorrheal rheumatism, and simple synovitis. I have not as yet used this method in cases of tubercular joint-disease, fearing that the resolution which might be brought about might cause a general tuberculosis, instead of the local disease.

At a meeting of the American Orthopedic Association recently held at Buffalo, where I read a paper on this subject, Dr. A. J. Gillette, of St. Paul, Minn., for whom I furnished some time ago an apparatus similar to the one before you, reported that he had used it in a number of cases with excellent results so far, but that he had not used the apparatus long enough to make a final report. Recently, through the courtesy of Dr. R. M. Woodward, I had the opportunity of using this method on what I consider very nearly a test case. Many of you will remember that at a meeting of the Cleveland Medical Society a month or two ago, Dr. Woodward reported an old case of gonorrheal rheumatism of some years' standing in a man about forty years of age. The doctor stated that many physicians had given advice in the case as to treatment, but up to that time very little benefit had been derived from the suggestions made; he asked for further advice as to treatment. At that time I suggested that my apparatus be tried, which suggestion has since been followed out. On June 16, in the presence of the house staff of the Marine Hospital, I kept the above patient's left knee in this apparatus for forty minutes. The temperature ranged for the most of the time from 310 to 340 degrees F., reaching at one time the extreme range of 360 degrees F., and remaining there for nearly five minutes. After the treatment the patient said that all the pain had left the joint; the motion of the joint was freer, and all creaking had disappeared. The house doctor tells me that since then they have been continuing the use of the apparatus in his case; that on Saturday night prior to last Sunday's storm the patient complained of his knee feeling much worse, stating his belief that a storm was coming, and requesting that the apparatus be used. This was done, and after the treatment the patient stated that the pain was all gone and "that he felt all right." The doctor tells me that the patient is receiving much benefit from the apparatus and is desirous of leaving the hospital.

We all realize how difficult it is to give relief in such conditions as rheumatoid arthritis and gonorrheal rheumatism. Yet I have had patients suffering from these conditions claim that the pain was relieved as soon as considerable heat was attained, and that the motility and the pain were both benefited for some hours. Anything that will give relief to these patients will be hailed with delight by the profession at large, and especially by those suffering from these complaints.

## A Plea Against the Meddlesome Treatment of Acute Gonorrhea in Women

BY MARCUS ROSENWASSER, M. D., CLEVELAND

*Professor of Gynecology and Abdominal Surgery in the Cleveland College of Physicians and Surgeons*

THE fact that we have as yet no reliable local treatment and no specific remedy for the cure of gonorrhea does not deter authors of text-books and writers of journal articles from making positive assertions about the rapid cures effected by the "early and thorough" treatment of this disease. Perhaps in no disease does experience more often go counter to such careless and highly reprehensible assertions than in gonorrhea during the first two or three weeks of its course, or in the acute stage. The "early and thorough" treatment, first extensively advocated by our German confreres was based upon a pathology which more recent observation has proven erroneous. Bumm had described the gonococcus of Neisser as a germ living only in the cylindrical epithelium of mucous membranes. Wertheim has since demonstrated the fact that the germ also thrives in squamous epithelium, in connective tissue and on the peritoneum. The vagina has been regarded as the main seat of the disease, and has constituted the chief point of attack in the early treatment. We now know that it is rarely primarily affected, but serves merely as a catch-basin for the infected fluids that enter from below and for the drippings that come from above. The disease has been described as ascending from vulva to vagina, hence to the cervix, and so on. Following the *modus operandi* of the sexual act, it becomes apparent that with the completion of the act the vulva, vagina and cervix have been simultaneously exposed to infection, and that the spreading "up the vagina to the vaginal portion of the cervix" (a) is a theory rather than a condition. A modern author (b) proposes to cure the gonorrhea in this catch-basin in two to six days by "constant irrigation." He says it will take a little longer by using a "copious vaginal douche" every two hours by day and every four hours by night. He then continues: "If so much douching is not well tolerated or is not available, the disease can be rapidly cured by the dry pack." Again, "the douching, disinfection and packing should be repeated morning, noon and night for the first two or three days, and after that twice a day for a week." He destroys our faith in the cure by the following caution: "Attention should be given to septic urethral and cervical discharges, or the vagina may constantly become reinfected."

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*Read before the Ohio State Medical Society at Columbus, O., May 28, 1896*

(a) Garrigues—Diseases of Women. P. 783.

(b) An American Text Book of Gynecology. P. 197.

Can there be a greater concentration of brutal energy than is embodied in the original "pack," which is designed literally to skin the vaginal epithelium?

(c) "First of all the vulva and vagina are thoroughly cleansed of the adhering secretion by means of a 1:1,000 sublimate solution; then, with the help of a Simon's speculum, the vagina and vulva, including every fold and recess, are energetically swabbed with a dossil of cotton-wool soaked in a one percent solution of the sublimate, and rubbed with it for several minutes, so that the superficial sheaths of the epithelium containing the gonococci are removed. The Simon's speculum, or some other with separable blades (such as Bozeman's, etc.), is essential for the purpose in view; by this means it is possible to distend the folds of the vagina to their utmost extent, and to obtain a complete controlling view of the whole process, so as to avoid missing any of the diseased patches. Special care is taken with the introitus, which contains numerous folds.

"The next step is copiously to dust over the vagina and vulva with iodoform, which is still more effectively applied by rubbing it into the mucous membrane with the tip of the finger.

"To complete the process, the vagina is with moderate firmness packed full of iodoform gauze.

"If the treatment is very painful, a thing which depends upon the intensity of the disease process, and the idiosyncrasy of the patient, a narcotic or anesthetic must be administered. The process is of value only when thoroughly carried out, but then it is certain to succeed.

"If, as is usual in rubbing the vagina, there occurs extensive capillary hemorrhage, it is only a favorable sign, inasmuch as it shows that at the bleeding points the diseased epithelial covering is for the most part removed, and, at the same time, a large number of superficial, perhaps diseased, capillaries are destroyed.

"The iodoform gauze is permitted to remain for three or four days, and then the whole process is repeated with the same thoroughness and over the same area. After four or five days more the gauze is finally removed, and then, for eight or fourteen days, the patient carries out a copious irrigation of the vagina with a sublimate solution of 1 in 2,000. The vagina is red and raw after the second tampon has been removed, and there is usually a copious purulent discharge, but the gonococci are annihilated, and have forever vanished." Sinclair's chief objection to the method quoted is "not so much its inefficiency as its severity."

The present method of rapid cure may vary in degree, but not in kind. The experience we have gained and the light we now have seem to me to

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(c) Schwarz, quoted by Sinclair in his Monograph on "Gonorrheal Infection in Women," (Wm. Wood & Co.) p. 385.

warrant the abolition of this refinement of cruelty, and to justify the substitution of milder and more rational means.

It is generally conceded that gonorrhea is a germ disease capable of producing inflammation of mucous membrane, connective tissue and peritoneum; that, like other infectious diseases, it is self-limited; that transplantation upon new soil reinvigorates the enfeebled germ; that in mild cases under favorable circumstances, such as rest, and protection against irritation or reinfection, it runs a course of four to six weeks; that its chief habitat is the urethra, cervix and Bartholinian ducts; that it is rarely located in the vagina, except its membrane be delicate, moist and succulent, as it is found in children, virgins, pregnant and aged women; that it may simultaneously invade the entire genital tract and thus cause a pelvic peritonitis shortly after infection, and that peritonitis due to the gonococcus is adhesive, not suppurative.

Leaving out of present consideration cases with delicate vaginal lining, the parts of the sexual tract simultaneously infected are the vulvar entrance, including the urethra and the Bartholinian ducts, and the cervical canal. The sphincter muscles at the neck of the bladder, and at the internal *os uteri*, are the natural barriers against the immediate introduction of germs into bladder or cavity of the uterus. If these sphincters happen to be relaxed, the infection can at once gain entrance into these organs. At first the gonococcus only penetrates into the surface epithelium. After a time upon irritation it becomes more virulent, and it lodges deeper. It is liable to forcible transportation by all manner of mechanical means, whether it be douche, finger, catheter, or sound. From the moment of infection the living tissues are engaged in resisting the invasion. Unless this reparative process be frequently disturbed, or the power of resistance be constitutionally insufficient, the vital forces will in about fifteen to twenty days have successfully thrown out a wall of limitation, or line of demarcation, beyond or beneath which the advance of the infection is stayed. This contact wall becomes gradually accustomed to the presence of the germs, which thus lose their former deadly effect, and themselves become exhausted for want of new supplies of favorable soil. The premature removal of protective, living covering, be it epithelium, lymph, mucus, or leucocytes, opens up non-resisting avenues for infection, and furnishes new food to invigorate the exhausted stock. Any treatment, therefore,, which does not, and cannot remove or kill all the germs, but does remove tissues that have become immune, weakens the resisting power of the remaining tissue, and thereby strengthens the remaining germs, besides supplying them with fertile soil for rapid reproduction.

In the treatment of acute infectious diseases we place the patient at rest, and surround him with the safeguards of diet, bowel movement, cleanliness, protection against reinfection and prevention of all possible, harmful influences. The contest between germ and life-preserving forces ends with the

death and elimination of the germ and its toxic products. Only complications, or cases that pass into the chronic stage require local treatment. Why not follow the same principle in the treatment of acute gonorrhea?

In cases seen very early urethritis is nearly always present. The usual "early and thorough" treatment does not apply to the urethra, and yet it is this untreated canal which gets well quickest, chronic urethritis being comparatively rare. In most cases seen later urethritis is not present. The symptoms have disappeared before the patient is aware of any serious trouble. The frequent voiding of urine keeps the urethra clean. Whether its chemical quality plays any part in the rapidity of the cure is still unknown. Again, the Bartholinian ducts cannot well be included in the "early and thorough" treatment on account of their inaccessibility. They either get well spontaneously, or become chronic.

The vagina and cervix constitute the great battlefield, upon which are concentrated all the squirtguns and other deadly weapons, including the noxious fumes of iodoform, to be used in the "early and thorough" extermination of the gonococcus. As stated in the premises, the vagina is rarely infected. Our energetic belligerents had, therefore, better keep their powder dry and in reserve for the exceptional cases. The cervix then is the citadel to which they must lay siege in downright earnest. The subtle enemy has meanwhile retreated into the various subterraneous crypts and dungeons of the citadel, whence our friends will find it no easy task to dislodge, or smoke him out. If they persist in pressing him too closely, they will find to their dismay that he will withdraw into the dome of the fundus, or even into the very pavilion of the tube, and there, rather than surrender, he will fire the magazine and bury himself and his tormentors under the ruins. It were better strategy to starve him out by cutting off supplies, than to drive him to desperation by assault. Let us cease fighting windmills and riding hobbies.

If the vulva alone is infected, the local treatment may be limited to frequent washing of the parts with weak solutions of boric or carbolic acid to keep them clean and to relieve the burning and itching. If, as is most often the case, the cervix is also affected, the vaginal portion is gently wiped with absorbent cotton, and the upper vagina is filled with powdered boric acid every second or third day. Sexual relations are prohibited. In cases of vaginitis with much pain and profuse discharge we must put the patient to bed. Keep external parts clean, and relieve pain with opiates. Upon subsidence of the acute tenderness of the entrance to the vagina, non-irritating, cleansing douches, or the dry treatment with powdered boric acid may be given to diminish the amount and virulence of the discharge. Not until after the disappearance of acute symptoms is it advisable to begin more active, local treatment, if any be needed. In pregnant women infected at term, the additional precaution of thoroughly washing the vagina with soap, and disinfecting with carbolic acid or creolin at the onset of labor is indicated, just



as is done in preparation for any vaginal operation. It goes without saying that the cervical canal be left undisturbed for a time. Local treatment for acute endometritis or salpingitis is of no value and is too dangerous to be indulged in for pastime. The application of general principles in their treatment will suffice.

In conclusion the so-called "early and thorough" treatment is to be condemned as meddling and mischievous for the following reasons:

It is based on a pathology now discarded as crude and imperfect.

It is not applicable to all the tissues simultaneously affected, hence it is no cure.

The results at the end of the acute stage are no better than are those of a more rational though less exacting treatment.

It is cruelly painful and often dangerous, requiring an anesthetic for its proper execution.

It is impracticable, even in the hands of an expert.

Though the treatment is irrational, inefficient, severe and dangerous, the physician who does not practice it is stigmatized as old-fashioned, negligent and indifferent to the interests of his patient.

722 Woodland Avenue

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## Suppuration of the Lower External Attic or Prussak's Space

BY HOWARD S. STRAIGHT, M. D., CLEVELAND

IF a plane be passed horizontally through the drum-membrane and tympanic cavity on a level with the short process of the malleus, the drum-membrane and tympanic cavity will be divided into two portions. The portion of the drum above the short process is called Schrapnell's membrane or the *membrana flaccida* on account of its mobility. The portion of the drum-membrane below is called the *membrana vibrans*. The portion of the tympanic cavity below the plane is called the atrium. The portion above the plane is called the attic or attic space. The attic space is divided by the head of the malleus and incus and their various ligaments into two parts—the internal attic space and the external space. The external attic space is subdivided by the external ligament of the malleus into an upper and lower attic space. The lower external attic space is also called Prussak's space. Under normal conditions there is usually a communication between the attic and atrium. When the mucous membrane of the tympanic cavity is inflamed the swelling may cut off all communication between the two cavities.

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*Read before the Union Medical Association of Northeastern Ohio, at Canton, June 9, 1896*

January 21, 1896, I saw A. H., aged 23 years. One month before coming under observation he had been struck upon the nose by a bed-fellow. As a result of the blow he had great swelling of the face and outside of the nose, and also complete obstruction of the nose. An abscess on the right side of the septum developed in a few days. The pus was evacuated by the attending physician, and the nose speedily returned to its normal condition. One week after receiving the blow upon his nose an acute suppuration of the right ear developed, and when the patient came under my observation a very marked deafness had developed within a few days. He had had a discharge from the ear for three weeks, but had not had any pain in the ear since spontaneous perforation of the drum-membrane had occurred.

For a time the discharge of pus had been free, but for the last ten days has been much less profuse than before. The external auditory canal was partly filled with pus. He could not hear a watch either on mastoid or aural contact. After syringing out the canal I examined the drum-membrane. There was no bulging present. No perforation could be detected. Finally a pin-hole perforation was discovered in the extreme upper portion of the Schrapnell's membrane. It was too small to be seen, but a drop of pus was discovered in this situation and wiped away. When the patient inflated his ear by holding the nose and blowing with the mouth closed—Valsalva's method—the tiny drop of pus would reappear. The mastoid was tender on pressure immediately over the antrum. The atrium was full of pus. A free incision through the drum-membrane in the lower posterior quadrant was made and a liberal quantity of pus was evacuated.

Daily syringing, politizerization, and insufflations of boric acid, to be carried out by the family physician, were ordered. The patient could now hear a watch distinctly on both aural and mastoid contact. For four days after this visit he was very much improved. At the end of this time he had a sharp ear-ache which kept him awake for one entire night. He developed a marked mastoid swelling and tenderness, and his physician brought him back January 28, 1896—one week after the first visit.

The discharge of the ear had been copious since the paracentesis. The mastoid was swollen and very tender on pressure over the antrum, and the head was drawn slightly to the right side through the contraction of the sterno-cleido-mastoid muscle. A small polypus had formed and was partially obstructing the artificial opening in the drum-membrane. This opening had also partially grown up. There was a marked bulging of the upper posterior quadrant. The polypus was snared off and a long incision in the upper posterior quadrant of the drum was made. The application of a half-dozen leeches to the mastoid was ordered, to be followed by hot poultices continuously, rest in bed and occasional syringing with warm boric acid solution. A letter from the family physician two days later reported tenderness and swelling of the mastoid nearly gone; escape of pus still free and no

pain. A second letter three days after the second visit reported mastoid normal, no more discharge of pus, hears a watch three inches with this ear. A report February 12, 1896, states that the patient has fully recovered, and another report within a week from the present time confirms the previous statement that his recovery was rapid and complete.

Authorities differ as to the extent and location of the tissues involved in acute suppurative middle-ear inflammation. Dench, of New York, is of the opinion that in such disease the inflammation always starts in the attic space, and that if the lower part of the tympanic cavity—the atrium—becomes involved it is by extension of the inflammation downward. There is also a diversity of opinion as to the extent of the inflammation in the attic space. Some authorities hold that the inflammation of the attic is limited to the lower portion of the external attic or Prussak's space. There seems to me to be good reason for believing that the following might happen: First, an acute suppuration of the mucous membrane of the atrium with no involvement of the tissues in the attic space. Second, an inflammation of the mucous membrane and connective tissue of the attic space without any involvement of the atrium. Third, an inflammation involving both the atrium and attic. Recent clinical and anatomical observation has definitely proved that an inflammation of the lower portion of the external attic with no involvement of other portions of the attic or atrium can occur. The case reported was undoubtedly one of this character. While the rôle played by various bacteria found in acute suppuration of the middle-ear is not as yet definitely decided, it is supposed that acute suppuration of the attic is due to the invasion of pathogenic germs. Such inflammation occurs often in measles, scarlet-fever and diphtheria, diseases in which germs are supposed to play so important a part as etiologic factors. It can be readily seen how such an infection could occur in this case from the condition of the nose. The inflammation before the formation of pus occurred had undoubtedly caused so much swelling of the tissues that all communication between the lower external attic space and atrium had been shut off, and a perforation of Schrapnell's membrane had taken place with a free discharge of pus into the external auditory canal. As the inflammation of the lower external attic subsided the communication between the two spaces was reestablished with consequent filling of the atrium with pus and almost absolute deafness. The reason for the paracentesis and evacuation of this collection of pus is self-evident. The lighting up of the inflammatory symptoms four days later might be explained in various ways. It might have been due to the early or too forcible use of the air-bag. I hesitated before recommending its use, but finally considered it safe to do so. The blocking up of the pus might have had something to do with the increase of inflammation of the mucous membrane lining the antrum of the mastoid—the all-important feature in the case at the second visit. Acute suppuration of the attic space with per-

foration of Schrapnell's membrane is of grave significance, because drainage is so imperfect that chronic suppuration may occur in spite of any treatment during the acute stage, also because the inflammation may interfere with the blood-supply of the incus or malleus, and a necrosis result with the formation of a focus of possible infection of the intracranial contents for years to come. Involvement of the mastoid with all its grave consequences is of very frequent occurrence. The possibilities of such disease are legion and admit of a cursory glance only in the time allowed.

*185 Euclid Avenue*

### Report of a Case of Pott's Disease of the Spine

BY JOSEPH F. HOBSON, M. D., CLEVELAND

THE patient, D. W. C., a minister, aged 45 years, gave a good family history. There was no tuberculosis, no scrofula and no known instance of any spinal complaint in the family. The father died of inflammatory rheumatism; the mother of fatty degeneration of the heart. The patient inherited a good constitution. His early life was divided between school and healthful labor. He entered the ministry at 21 years of age. At 24 he went to the mission field in China and remained there eight years. Returning to America, he rested one year, re-entered the ministry in this country and has been active ever since, a period of three years since his return. His only previous dangerous sickness was an attack of pleuro-pneumonia in China, 16 years ago. He evidently made a perfect recovery from this. He had always been a strong and rapid walker.

In October, 1893, at Bellaire, O., with no history of injury, he was taken with a pain in the lumbar region. His physician diagnosed it as lumbago. It did not yield to treatment. After six weeks the physician said it was some nervous trouble. After that he had no treatment except belladonna plasters and phenacetin to relieve the pain. He grew worse until January, 1894, then slowly better until spring. He often walked from five to ten miles a day during the summer of 1894 with now and then a little pain, indicating some lingering trouble. During this year he found relief while sitting, by pressing his hand between the spine and the back of the chair.

During the autumn of 1894 he had some pain in the back running down into the thigh like sciatica. Removing to a neighboring town, his general health grew better, he gained in weight and was well all winter, excepting that some slight pain in the back was experienced. In the latter part of February or first of March, 1895, new symptoms were exhibited. The patient had much pain, and unprecedented difficulty in walking. The nerves of respiration seemed to be affected. In April or May he first consulted Dr.

*Read before the Cleveland Medical Society, June 26, 1896*

A. H. Hewetson. The symptoms and the analysis of the urine all indicated rheumatism, and for this he took treatment irregularly through the summer till July 29, 1895. He was sometimes better, sometimes worse, with no material change. He took a month's vacation at this time in Detroit and Mt. Clemens, Michigan. July 30, Dr. Devendorf, of Detroit, diagnosed the case as rheumatism, prescribed Tongaline and advised the Mt. Clemens baths and massage. August 1, the patient noticed great difficulty in keeping himself in an erect position, and a strong tendency to lean forward. August 4, in rubbing the back the patient noticed a slight angular projection on the spine at the ninth or tenth dorsal vertebra. He was alarmed, and after several times examining it by the aid of mirrors, and having read in the Encyclopedia of Angular Curvature of the Spine, on August 6 he went again to the doctor, who examined it and expressed an opinion that it was caused by some contraction of the muscles produced by the rheumatism. The patient asked him if it might not be "Angular Curvature of the Spine," caused by caries of the bone; the doctor thought not. Mt. Clemens baths were taken every day for a month and Tongaline was used internally. At the end of the month the general health was much improved, there was an increase in weight of five pounds, but he was still subject to much pain after standing or walking. At the end of that time Dr. Devendorf still adhered to his original diagnosis and assured him that he need not fear the spine. Returning home at the end of August, the patient was at first better, but by September 7 was so bad again that he called his family physician, Dr. Hewetson, and directed his attention for the first time to the spine. Dr. H. expressed the opinion that the trouble was not rheumatism, but, as the patient was about to leave for conference, merely advised him that he would need a plaster jacket when he came back, and meanwhile cautioned him to be careful. After returning from the conference the Doctor made a careful examination and pronounced the trouble "Pott's Disease of the Spine;" this diagnosis was made September 8. Between this time and the latter part of October two plaster jackets were applied but did not prove satisfactory and were not worn. The patient grew worse; he had much pain in the back and right thigh and knee, the limb became drawn up and he could not rest in bed. As he seemed to incline to the original diagnosis and reluctant to try the plaster jackets again, consultants were called. They readily confirmed the diagnosis of Pott's disease. This examination was made on October 27, 1895, and indicated disease in the anterior portion of the spine, also at the right side. The ribs on the right side dropped almost to the hips. The right side of the body was shorter than the left; the right leg drawn up and very painful. The general health was good as were the appetite and digestion. Pulse and temperature were normal. On November 1 Dr. Hobson, of the Flushing Hospital, applied a plaster-jacket, suspending the patient with the usual apparatus. This jacket was kept on solid for five days, then

cut open, bound and laced; after that the jacket was taken off at night and put on each morning while the patient was suspended. From this time on the curvature grew no worse but rather better. As soon as the jacket was put on the right leg could be extended and all the pain formerly supposed to be rheumatism subsided. The evening following the application of the jacket, fever appeared for the first time. From this date there was fever every afternoon and evening for eleven weeks. It was very regular; usually the highest point was 100.4 degrees. Tonics were administered together with local applications of guaiacol and iodine. He began taking out-door exercise about November 15.

November 28 the patient returned home and again came under the care of the family physician. His fever continued, but without any rigors. Extension was resorted to each morning and seemed to make the fever worse.

His physician began to look for abscess, but it could not at first be certainly located. Medicines at this time were principally creosote, tonics and external applications as before.

January 18, 1896, the patient having gone to Cleveland to inquire about spinal braces, Dr. Hobson, of that city, located an abscess in the upper part of the right thigh and aspirated it drawing off a full pint of pus. From this time the fever subsided, the temperature not rising above 99.2 degrees. About this time extension was discontinued. The cavity filled rapidly again, and on February 11 it was again aspirated and somewhat more than one-half pint of pus drawn off. Antiseptics were injected but did not seem to ascend far. March 6 the abscess was again aspirated and a half-pint of pus drawn off, no antiseptics being used. After one week there was evidently some pus in the cavity. In about three weeks it had ceased to increase and soon grew less, and was finally absorbed. It was now fifteen weeks since the last aspiration, and the abscess has made no further appearance.

From the time of the first aspiration the patient gained in appetite, weight, nervous tone and strength. About April 15 he reached his full normal weight, 130 pounds. On January 26, after three months of complete rest, the patient partially resumed his ministerial work, and for the past month or more has been doing his full work. Dr. Hobson, of Cleveland, advised absolute rest in bed, but the family physician, from his knowledge of the temperament of the patient, thought this would not do. Dr. Sayre, of New York, thought best to keep the patient in good support and let him walk in the open air as much as possible. From the middle of March the callus could be traced; it is seemingly well-formed, and the joint ankylosed, but perhaps not yet in a perfectly osseous condition. The right side is still somewhat shorter than the left, but the lameness has grown less and less. Probably there will be no permanent perceptible lameness. The angular

curvature was perfectly checked by the first plaster-jacket, and will probably, when the patient is dressed, leave no apparent deformity. A plaster-jacket is still worn. The patient has at present a normal pulse and temperature, good color and digestion. His former height was five feet eight and one-half inches; his present height is five feet seven and one-half inches. About April 17, the abscess having disappeared, a hard egg-like lump appeared in the thigh, pressing up from the bottom of the cavity, very sensitive to pressure; it was treated with daily applications of tincture of iodine. In about one week the inflammation began to subside, later the lump decreased in size, and all tenderness disappeared. It has not given any trouble for several weeks, and now remains a small, inert lump, only perceptible on manipulation. It seems possible that a small piece of necrosed bone worked its way down into the cavity, where, after the pus was reabsorbed, it set up an irritation and began to work its way towards the surface; but inflammation being allayed by counter-irritants, it finally became encysted, and now gives no further trouble. The patient believes he is entirely cured.

429 Prospect Street

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### Report of a Case of Croupous Laryngitis

BY A. B. WALKER, M. D., OF CANTON

FRANCIS Abraham, son of Mr. and Mrs. G., aged three years, was taken sick March 4, 1896, with what his parents considered a very bad cold; was quite hoarse, but played around the house and went to the table for his meals. This condition continued to grow worse, until March 8, when a physician, who called to examine one of the family for life insurance, examined the child and pronounced the trouble bronchitis and recommended mustard plasters applied to the chest, followed with poultices and white pine expectorant. Up to this time the usual home remedies for a cold had been tried with no benefit.

On the morning of March 9, at 9 A. M., I was called to visit him, when, upon examination, I found a very sick child. His voice was hoarse and his cough had a metallic ring. Breathing was very difficult, in fact the child was suffering for want of oxygen; he was stupid and dull with blue appearance of his finger nails. His temperature was 102 degrees, and pulse rapid and weak. His pharynx and tonsils were quite red, but showed no deposit of membrane. Owing to his age and the highly sensitive condition of his throat a laryngeal examination could not be made. However, I was satisfied that he had croupous laryngitis, not diphtheritic in character, as it was not attended by any of the septic features of diphtheria, such as a swollen condition of the glands at the angle of the jaw, etc.

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*Read before the Union Medical Association of Northeastern Ohio, at Canton, June 9, 1896*

Owing to the length of time the child had been sick without any improvement, and the marked dyspnea and cyanosis, I gave a doubtful prognosis. An emetic of yellow sulphate of mercury was immediately given, followed by inhalations of lime and turpentine and hot water with small doses of aconite and ipecac. The temperature of the room was ordered kept at 70 to 72 degrees. Hot drinks of milk and water were to be taken freely. He got but little relief from this line of treatment, and the next morning, March 10, at 2 A. M., I was hastily summoned to see him, when I found him much worse. Dyspnea and cyanosis were more marked, the child fighting for his breath and begging for cold water. The cold water was allowed, and later ice substituted, which he ate with a relish and would eagerly reach for it. The ice gave him immediate relief, and after eating a dessert dish of it he again vomited quite freely and went to sleep, resting fairly well, taking ice occasionally until the evening of March 12, when the ice and everything else failed to give him relief. Intubation or tracheotomy was then recommended as the only hope of relief, but as the child was so very weak with breathing and circulation poor, I did not give the parents much hope from either, and they refused to give their consent. Stimulants and nourishment were freely given through the night, but we expected the child to die at any time. Next morning at 9 A. M. the child was still growing worse, and so continued until 3 P. M., when the father asked me if it were my son would I have him operated upon. I told him I certainly would have the child intubated, and he finally gave his consent. At this hour, 3:30 P. M., the child's extremities were cold and cyanosis and dyspnea were very marked. The body of the child was covered with a cold perspiration, and he was lying in a stupid condition from carbon dioxid poisoning, the pulse was feeble, and temperature below normal—a rather hopeless case for intubation. With the assistance of Dr. E. O. Morrow, of our city, I succeeded, after several attempts, in getting the tube into his larynx. The child made no resistance. It was quite difficult to insert the tube, as the larynx seemed so nearly closed. Quite an amount of mucopurulent matter was removed from his larynx during the attempts to insert the tube, and after the tube was in place great quantities were coughed up.

Relief from his difficulty of breathing was immediate, and in a very short time all the other bad symptoms cleared up. As soon as he could get oxygen into his lungs the cyanosis cleared up like magic, and he looked like a different child. He was then allowed milk, whisky, ice cream and any liquid food he desired, which he took freely, lying with his head a little lower than his body. The tube was left in place for a period of six days during which time he took liquid food freely and gained wonderfully in strength. He continued to spit up frequently all the time that the tube was in place. He could not speak aloud during this time, and it was three weeks after the tube was removed before he could do so. He still coughs some and is a little hoarse at times, but is rapidly gaining in health.



## Cleanse the Alimentary Canal

WITH the advent of hot weather the occurrence of diarrheal affections both in adults and children is becoming frequent. Not only in domestic practice, but by some physicians, the mistake is made of attempting at once to check the intestinal flux by means of opium and astringents. The result of this, if successful, is to imprison within the bowel toxic and irritating materials that keep up the disorder, and if unsuccessful in checking the flow, the patient is more or less depressed by the narcotic drug, in addition to the intoxication resulting from absorption of intestinal poisons. No matter whether the case be seen late or early, the first indication is to clear the alimentary tract. For this purpose a high enema may be used, calomel given in small doses, or, as we prefer, castor oil and aromatic syrup of rhubarb may be given together in equal parts, namely, about a teaspoonful of each for a child, a tablespoonful for an adult. After this has secured the removal of the offending materials from the bowel, intestinal disinfection, by means of salol, salophen, benzoyl guaiacol or guaiacol carbonate, benzonaphthol, creosote, or whatever other drug the physician prefers for this purpose, is in order. The diet must be restricted to small quantities of nonfermentable food, preferably liquid. Pancreatized, sterile milk usually answers the purpose for adults. With children, on the other hand, it is well to avoid milk, and beef-juice freshly prepared at home by expression from a piece of warm meat, or preferably, in some cases, barley-water, is to be substituted during two or three days. When the pain is severe and there is a tendency to continuance of a watery discharge from the bowel after all irritating matters have been removed (and to make sure of this a high enema should be given), Dover's powder or other appropriate preparation of opium may be employed with due caution, both in the case of children and in the case of adults. In cases in which pain and tenderness are localized in the region of the cecum, appendicitis is nowadays often improperly diagnosticated. It is true that in very many cases the cecum and appendix share in a general catarrhal process. In such cases it is well to place an ice-bag over the cecal region until the pain and tenderness subside. An important diagnostic point is the presence or absence of rigidity of the abdominal muscles upon the right side. In the absence of rigidity or "on guard" condition, as it is now termed, acute appendicitis should never be diagnosticated unless a collection of pus is palpably to be demonstrated.—*The Philadelphia Polyclinic*

# Cleveland Journal of Medicine

THE OFFICIAL JOURNAL OF THE  
Cleveland Medical Society

AND OF THE UNION MEDICAL ASSOCIATION OF NORTHEASTERN OHIO

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## EDITORIAL

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### Style and Science

THE task of editing a medical journal differs in some respects from the work connected with most other periodicals. Medical papers are largely records of observed facts; they are conveyed in terse language, usually too terse; corrections by the editor are most of them made necessary, not by the ignorance, but by the carelessness of the writer.

The English language, as is true of every tongue used by a live people, is a moving caravan; an advance-guard of slang, a skirmish-line of words modified by spelling-reform, a compact army of words fixed by custom and sanctioned by use, a rear-guard of terms obsolete and those which should become so. A dictionary is not the pioneer of reform; it marshals and aligns

the words made by the people. It is the belief of this JOURNAL following March, Gould and other linguistic apostles, that the language of medical, as of other English, should be simplified. Along this line it is well within the province of journalism to lead the way. We are not so foolish as to think our vernacular can be suddenly purged of all its redundant vowels and useless terminations. It would be as easy to change English into Volapuk at once. Changes there are which can be made now, and others which may follow after.

An argument for "fonetic" spelling in general is not needed in this place. It will suffice merely to say, that to weed out the orthographic impertinences of the middle ages, introduced by the monks for their amusement and the perpetuation of their literary trust, would enormously lessen the work of learning the language for both natives and foreigners. The inconsistencies which arise in the course of a gradual change of this kind are more than offset by others removed. As an instance merely, the good old English word *practician* is in every way better than *practitioner*, the absurdity of which is manifest when it is seen that "*musicianer*" is constructed on the same plan. It is unfortunate that we are possessed of two adjective endings, *ic* and *al*, but this wealth is no excuse for squandering them both on one word; and it should be remembered that some words, as *medicine*, have *ic* in the root, and have more need of the termination *al* in the adjective form than have *pathological* and *antiseptical* and *antiphlogistical*, and other verbal *saurians*, some of which still, unfortunately rear their heads in print. Our proof sent to the author for correction often comes back to us with the useless *al* added to *chemic* and *physiologic* and *pathologic*; with *a* or *o* introduced once more to *anemia*, and *ameba*, and *hemorrhage*; with *antitoxin*, *intrauterine* and *presystolic* linked instead of *welded*; with the *me* added to *program* and *centigram* which is necessary in French but not in English; with *bromid* and *chlorid* turned back to the older *bromide* and *chloride*. Of course, these words are promptly reconverted—it is hoped without offense to the authors whose papers they adorn—and for a sufficient reason, uniformity.

This JOURNAL aims to make its pages as much as possible English rather than Latin, French or German, another respect in which we must ask the indulgence of our contributors. So much for matters editorial, about which most physicians need not vex their souls. One or two suggestions may be ventured to intending authors, which, if followed, will make their articles more readable, or, at least, will lighten the task of revision. Before

sending in a paper look it over to see if its strings of words make sentences. A noun and an adjective do not make a sentence. The ordinary medical paper, as it reaches the editor, is jagged with subjectless verbs; it is characterized by a Chinese lack of pronouns and of articles. It is hard to tell whether the man of science scorns them, or whether in jotting down his bedside notes betwixt feeling a pulse and flushing a colon they escape in the general confusion. A good part of an editor's work consists in the injection of parts of speech into these same bedside notes and laboratory jottings. To pierce into the realms of thought a sentence should be smooth as well as pointed. The true mission of a scientific paper, whether medical or not, is to convey observed facts and opinions; the language used should be, above all things, accurate; words should be selected which say the thing meant and nothing else; while mere verbiage is weak, it should be remembered that there is no obscurity so complete as that which results from an ill-chosen condensation. "Mother died of typhoid. Father of sunstroke. Sick three days. Temperature 104," leaves us in pleasing uncertainty whether the observer or the patient is the orphan, who had the illness which endured three days, and whether the patient or the apartment registered a temperature so much above the normal. These seem small matters, and it is devoutly to be hoped that scientific facts will never again be overlaid as they were in Molière's time with a thick crust of learning; so thick and so offensive as fully to justify his bitter gibes. There is no indication of it in the clear vigorous writing of Starr, of Gould and of Gowers, and it is in the obviously good results of the combining of keen observation and clear diction by such men as these that we find the excuse for a plea for more attention to what seem at first glance the unessentials of medical writing.

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### The Hysteria of Crowds

MUCH has been written of recent years by psychologists in regard to the mental phenomena of mobs and large crowds. It has been clearly shown that the intelligence of a mob is far below the average intelligence of the men composing it, and it is also clear that humanity in great masses passes into a mental state closely analogous to that of the hypnotized subject. Just as the latter obeys every suggestion of the hypnotist, so the mob is in a state of mental receptivity, with suspended inhibition, such that the suggestion to commit an act of violence is at once responded

to by violent acts on the part of the mob. Suggestion received through the eye, as seeing others committing unlawful acts, seems more powerful than suggestion received by the ear from the words of leaders, although the latter also has its due effect.

It not infrequently happens that a body of police, in charging a mob to clear a street, have the most perfect control of their tempers until one of their number for due cause clubs an opponent, instantly the whole line of police catch the infection and begin clubbing right and left without regard to age or sex of the persons clubbed. Police and military officers should be well-informed in regard to this tendency of the human mind, as, once set in motion, this sort of violence cannot be easily restrained, and the individuals committing the violent acts are not really responsible for what they do.

The same tendency of masses of men to become hysterical is noticeable in the great political conventions of the day. A word or an act, which to any one of the men composing such a meeting would appear silly if met under ordinary circumstances, becomes in these conventions a powerful suggestion in favor of a certain candidate or measure. The so-called "dramatic" features of these conventions are all of this order. A mere emotional straw frequently settles the fate of parties and of men.

This cursory review of the psychology of crowds would be incomplete without notice of the same phenomena appearing frequently among the lower animals. The wild and frightful stampedes of buffalos and cattle upon our western plains are apt illustrations of this tendency. It would seem, therefore, that humanity in this as in other things but inherits the animal tendencies of its own evolutionary antecedents. Confirmatory of this is the fact that the ruder and more uncivilized the human mob the more fearful its work. Illustrations of this are plenty in history and in the everyday record of the world's doings.

Alone of all philosophers the optimistic evolutionist (and all evolutionists must necessarily be optimists) can rest serene in the firm conviction that, with the spread of education and culture among the masses, mob phenomena will become milder and more rare. As man gains increasing control of his animal nature this brute inheritance, with others, will always tend to gradual extinction.

## The Holiness of Instinct

UNDER the above caption Professor Woods Hutchinson, M. D., of Buffalo, in the July number of *The Monist*, writes an article which ought to be read by every physician. Much has been written about man's instincts, some writers even denying that he has any. The above article is by all odds one of the best things that has ever been written upon the subject, and an attempt will be made to give an intelligent summary of its views.

Curiously enough many medical writers, who denounce instinct as an unsafe guide for matters of health, quote as illustrations of the evil results of following instinct man's violations of that very instinct. Thus has grown up a good deal of confusion about the subject. Man's ungoverned appetites are not instinct. A clear definition of our subject, instinct, is therefore desirable. Professor Hutchinson's definition, "Instinct is the crystallized experience of thousands of generations," expresses the truth well.

The old idea, fostered carefully in all times and ages by priestcraft, that man is made up of two natures, a bad animal nature and a good spiritual nature or soul, has taught us from childhood that all man's instincts are bad and must be repressed. The Old Testament taught that man was originally pure and good and that his evil nature was engrafted subsequently. The New Testament and Christian theologians generally have taught that man was originally bad while the good was a new growth. "The two-fold constitution of man's nature, from a mere figure of speech, has come to be regarded as a literal material fact."

"Whatever is flesh is sin" and "the mind of the flesh is enmity against God" we are taught. The truly "spiritually minded" creeds openly wage war upon the body as being the soul's bitterest enemy. We are advised to desert wife, children and parents, to abstain from food and drink and shelter, to scourge our bodies, to expose ourselves to cold and heat, to go unwashed, and many other unnatural and disgusting things, with the avowed purpose of educating the soul. "In fact, the principle appears to be that the more a man can humiliate and torture his body the more he will glorify and please the God who made it." Paul commands us to "mortify the flesh and the affections," and learned theologians have declared that the deeds of righteousness of the unregenerate shall be counted against them as sins on the great day of judgment. "Wherever this belief has gone it has written its

progress in letters of blood." Fortunately, while surviving in the formal theology of the modern church it has, like many other beliefs, become practically a dead letter.

The "principle" of every sin that can be mentioned, except lying, is a natural beneficent instinct. Crime is simply lack of control. Right and wrong are broadly considered purely relative terms. Nearly all our crimes are acts which if done for good motive are natural and beneficent. Passion is blameless appetite run riot. Gluttony is the abuse of natural appetite. Killing a fellow-being is wrong only if done wantonly. If done in defense of country, of friends, of life, of property, it is not a crime. "Morality, like sanity, is everywhere, and always a question of balance, of control, of moderation." Darwin, almost alone of all philosophers, saw that the true source of morality is in the social instincts and sympathies which are derived from the warm, beautiful and unselfish family affections. Not from tempered self-interest, nor from extraneous revelation does it come.

Two-thirds of human virtues are to be found in varying degree among different members of the animal kingdom. The pedigree of our virtues then is longer than the race itself; but how few of our vices are inherited from our lower (*sic!*) predecessors! Nearly all the vices are purely human accomplishments. "Indeed, it would almost seem as if one of the most common uses that man had made of the elevation he had attained had been to fall from it." But our virtues are older than we are, while our vices are but of mushroom growth.

Many physicians have maintained that it is man's instinct which leads him at times into deviations from normal health. If this be so evolution is not true, for instinct is but accumulated and inherited experience, and experience does not teach falsely. Man's instinctive longing for fresh air, sunlight, water, exercise, food, etc., would, if more freely indulged, undoubtedly make him healthier. No one, for instance, maintains that the appetite for narcotics is instinctive.

Up to a century ago medical men, as well as theologians, believed in the duality of man, and hence in the demon-theory of disease. So we have inherited our bitters and our purges and our emetics and our blisterings and bleedings, all originally directed to driving the disease-demon out of the body. The more nauseous a medicine the more powerful it was supposed to be. But in its origin "the distrust of the instincts in disease is not medical, but priestly."

Today we follow our natural impulses. Instead of blistering or burning a wound to "establish suppuration," we cleanse it and close it up in its own lymph as do the animals. In fevers we no longer forbid food, water, air and light but just the reverse, and again the adoption of the methods of nature has been beneficial. In morals, instinct is a true guide. Indeed, morality itself is but instinct and no external entity. "Morality is the flower born of all the struggling impulses of lowly but warm-hearted human nature."

It is the physician's duty to teach mankind that the fancied enmity between soul and body, which is still preached by many theologians, is a mere myth. The nearer a man lives to his natural instincts the better he will be, else Creation is a failure and the Universe a freak.

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ATTENTION is directed to an editorial from the *Philadelphia Polyclinic*, entitled "Cleanse the Alimentary Canal," which we reprint elsewhere.

It comprises the most modern ideas and most common-sense views of the treatment of affections of the alimentary canal. The advice given there could not be better said and cannot be too closely followed by the profession, especially during the heated term.

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OUT of every 75 persons convicted of murder in this country, only one is hanged. Every year since 1890 the number of murders committed in the United States has more than doubled that year. The number of murders committed here in 1890 was 4,230; in 1894, 9,800; in 1895, 10,500. Be the cause whichever one of many it may, it is proof positive that capital punishment as a preventive of crime is a failure and should be abolished. Imprisonment for life at hard labor for the State, without pardon or reprieve, would be equally effective and more humane.

What wonderful faith is required to write the above paragraph! Capital punishment is a failure because murders are increasing. No other factor is worth considering evidently. It is hopeless to attempt to convince the author of the above that there is any flaw in his reasoning, but others will be able to see a little further. Only one convicted murderer in 75 is punished by death, but this is evidently not regarded as having any bearing on the problem. In nearly all communities the death penalty is rarely adjudged a murderer by a jury. Wherever it is possible, life or term imprisonment is ordered. If the logic of the paragraph quoted at the head of this article is correct, it proves, in the light of facts, that life imprisonment does not deter prospective homicides from pursuing their occupation. The efficacy of the death penalty as a deterrent to murder cannot be judged until it has had a fair trial.



**F**IN-DE-SIECLE degeneracy appears to be capturing the medical as well as the lay press. We have previously noted the pornographic pictures published by some of our western contemporaries. Most of them have ceased, although the worst offender in this direction has recently published a full-page illustration of a perfectly nude woman—the picture purporting to have been photographed from life, especially for the journal in question! A much more frequent and growing offense is that of giving prominence to translations of French monographs upon the history of prostitution, upon the various functional sexual derangements of both male and female, and upon kindred topics.

It is true that the profession very properly needs to be well informed about these matters, but the detailed history of the symptoms and acts of these cases can hardly pass for scientific information. Rather is it an appeal to the base in the physician which he must needs have in common with human-kind. It can serve no good purpose and betrays on the part of the editors a low standard of ethics.

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**J**UDGE DISSETTE, of this city, in sentencing Dr. Norman M. Geer to two years in the State penitentiary for criminal abortion, gave utterance to sentiments for which the medical profession can thank him. Among other things he said: "It is debasing to society, this practice of infanticide. One thing that occurred during the trial was like a nightmare to me. This was the exhibition of that tiny human form in a glass jar, such a sight that the poor girl begged the court not to be compelled to look upon it. This is a horrid crime. I do not wish to make an example of Dr. Geer; but a medical man ought to have more regard for his profession than to commit an abortion. It may be lucrative for those who go into the business, but it casts a reflection on the whole body of physicians. Our idea of the sacredness of human life must be preserved and wholesale murder prevented. The sentence of the court is that you be confined in the penitentiary for the period of two years at hard labor."

If a few more of the misguided and dishonorable members of our profession who descend to this nefarious business could have justice thus meted out to them, the credit of the profession would be the better therefor.

An appeal has been taken to the higher courts in this case, consequently it is not yet certain that the sentence will be carried out.

## Resolutions Passed by the State Board of Medical Registration and Examination

**R**ESOLVED, That all medical colleges in the United States requiring a minimum of three years' study of medicine and two courses of lectures for graduation prior to 1886, and possessing proper facilities for teaching, and a faculty embracing the chairs of anatomy, physiology, chemistry, materia medica, therapeutics, medicine, surgery, and obstetrics, shall be recognized as in good standing, and diplomas issued by the same and properly verified shall entitle the holders thereof to register as graduates in medicine under the laws of Ohio, providing that no certificates shall be issued to any applicant upon proof that his or her diploma has been obtained fraudulently or in violation to the published rules of the colleges issuing the same.

2. Resolved, That for the ten years ending February 27, 1896, all medical colleges exacting the foregoing requirements and possessing facilities and a faculty as specified in the foregoing resolution, shall, by virtue of such facts, be recognized as in good standing to, and including the year 1892, but that no medical college shall be recognized as in good standing which has not since 1892 possessed the foregoing facilities and faculty, and which has not, in addition, exacted an entrance qualification and attendance upon three regular courses of lectures as a condition of graduation.

3. Resolved, That on and after July 1, 1899, no medical college shall be recognized as in good standing which does not require the entrance qualification prescribed by the Association of American Medical Colleges as a prerequisite for matriculation; which does not possess an adequate equipment for teaching medicine; which has not clinical and hospital facilities based upon a minimum municipal population of fifty thousand, and which does not have an active faculty embracing the departments of anatomy, physiology, chemistry, therapeutics, materia medica, surgery, medicine, obstetrics, histology, pathology, bacteriology, ophthalmology, otology, gynecology, laryngology, hygiene, and state medicine; and which does not enjoin attendance upon 80 percent of four regular courses of instruction, of not less than 26 weeks each, in four different years, and which does not exact an average grade of 75 percent on examination as conditions of graduation; providing that the rule relative to population as a basis for clinical and hospital facilities shall not apply to institutions under State control, and that by virtue of such control receive, gratuitously, patients from all parts of the State in which such colleges are located.

OFFICIAL PROCEEDINGS  
OF THE  
**Cleveland Medical Society**

REGULAR MEETING, June 26, 1896

*The President, DR. COOK, in the chair*

Society called to order at 8:10 P.M.

NOMINATIONS FOR MEMBERSHIP

Three, including that of Prof. J. C. WILSON, of Philadelphia.

ELECTION OF MEMBERS

DR. B. CHAPMAN, of Copley, was elected a nonresident member.

**Report of Cases and Exhibition of Specimens**

DR. C. A. HAMANN

*Three Cases of Goiter*

I desire to present this evening three cases that illustrate the effects of the administration of thyroid extract in cases of goiter.

This young man, eighteen years of age, presented himself with a large, soft, rather vascular goiter in which a thrill could be felt over the superior thyroid arteries. The goiter was of one to one and a half years' standing and was already beginning to cause some symptoms referable to pressure on the trachea.

He received the thyroid extract, prepared by Armour & Co., of Chicago, each tablet containing two grains of desiccated thyroid, and representing one-sixth of the weight of a sheep's thyroid gland. After taking some twenty of these tablets I measured his neck and found it  $1\frac{1}{2}$  inches less in circumference than before the use of the drug. He has subsequently taken more tablets and there has been a further diminution of three-fourths of an inch, although lately the diminution has been very slow. The symptoms of dyspnea have partly or entirely disappeared. The neck is decidedly smaller but I do not suppose the goiter will entirely disappear.

These two boys, aged eight and ten, presented the same kind of a goiter; soft and vascular; a thrill could be felt over the superior thyroid vessels. Neither exophthalmos or acceleration of the pulse was present.

With both of these cases the tablets caused diminution in size, and in the smaller of the two the gland is now nearly normal. There is a diminution of more than an inch in the circumference of the neck. The vascularity was decreased considerably.

I might state that at the recent meeting of the German Surgical Congress Bruns reported three hundred cases of goiter treated with thyroid extract. He found that it caused a decided diminution in the size and vascularity of the tumor. Some cases were completely cured, others very much relieved.

In experiments on animals the colloid masses decreased very decidedly in every case. Some of the spaces were completely or nearly obliterated. In some others there seemed to be a more active and normal function of the part.

It has been shown by the researches of Baumann that in the thyroid gland there is iodine present, and certain authorities believe that the action of the thyroid extract is that of an iodine compound.

I believe in these two boys the abnormal swelling of the thyroid will entirely disappear; in the oldest of the three I do not think it will entirely disappear, but the symptoms have diminished and he would now be better prepared for operation, as the tumor is less vascular. The two smaller boys are brothers. No other treatment was used in these cases.

### Discussion

DR. C. F. HOOVER: I have used a thyroid extract in about twelve cases, and in most the thyroids have diminished in size. Dr. Hamann says the more vascular the tumor the more favorable the result of the treatment. I had one case where the enlargement was of an interstitial type. The right lobe was enlarged to the size of a goose-egg, and quite firm. One would say the vascularity of the tumor was diminished rather than increased. On administration of the thyroid extract the infiltration of the skin disappeared, and greatly to my surprise the lobe of thyroid entirely disappeared. It was evidently a fibrous infiltration of the thyroid associated with a scleroderma. The etiologic element must have been quite different from the general etiologic element in the struma. One case—a school-girl—had a large struma which entirely disappeared on the administration of the thyroid. She was a very intelligent girl about twelve years of age, who stated nearly two-thirds of the girls in her class had enlarged thyroid. I have not had an opportunity to confirm the girl's account of it.

I would say that I had one case of cretinism in a boy nine years of age. The boy had not grown at all for a year and a half; he had all the marks of cretinism. In that case I procured the sheep's thyroid and had an apothecary make the extract. The boy improved very greatly.

DR. H. J. HERRICK: These cases of goiter are interesting. In my experience I have seen many of them. I now have a case under treatment of about three months' standing. It is that of a young lady about eighteen years of age. When she first came under my care about three months ago her neck had a circumference of seventeen inches at first, but it is now reduced to fifteen. The treatment I gave her was the use of cold and the application of constant pressure. It is a well-recognized principle that constant pressure causes absorption. I apply the pressure by an elastic webbing put around the neck and fastened, so as to give a constant pressure without interfering with respiration or any of the processes of deglutition. I speak of this case because there is a reduction from seventeen to fifteen inches and the case is practically cured. I have had cases where there was an exophthalmic feature, I recall now, where it would have been much better to have used this recent treatment.

DR. J. A. RILEY: There is no doubt but what the thyroid extract has quite an influence on the goiter, but there is one point that has not been brought out tonight, and that is the iodine treatment. I have treated quite a number of these cases of enlarged thyroid gland with equal parts of compound tincture of iodine and *aqua ammonia* rubbed on twice a day, and find

in a month or six weeks it reduces the thyroid and practically cures the case; and before I would operate on a boy of that kind I would use something of that form. I would not operate until I had tried the iodine applications, and might give internally the iodide of iron.

**DR. A. F. HOUSE:** My experience with iodine by injection or locally applied in enlarged thyroid is that it has rather increased the trouble than diminished it.

**DR. C. A. HAMANN:** In reply to Dr. Holliday's question I would state that there is a distinct factor of heredity in some of these cases.

With regard to the application of counter-irritants and injections, my experience has been unfavorable. Furthermore, if they precede operation it renders the operation more difficult on account of adhesions. No careful surgeon would care to operate in cases where iodine had been used.

In my discussion of these cases I intended to present the unfavorable results. A young woman presented herself to me with a very large and vascular goiter. I gave her Armour's extract and in six days there was a decided diminution in its size. The next lot of tablets which she took was of English make. The girl took a number of these but never presented herself again. I learned that after the use of these tablets she became very ill and lost much flesh. So there is sometimes a deleterious action. To what this is due I am unable to say. This has been met with by many observers.

We all know that there are certain localities in which goiter is endemic. It has been demonstrated by Kocher that there are certain springs (Kropfquellen) the water of which, owing to contained organic materials produces goiter.

**DR. M. ROSENWASSER**

*A Case of Strangulated Hernia*

I have a case to present which is interesting in so far as it concerns the age of the patient. About a month ago Dr. Peskind requested me to see a lady in her 87th year suffering from a strangulated femoral hernia. I was called at 8:00 o'clock in the evening. Taxis had been tried twice during the day unsuccessfully. I made a third attempt under anesthesia without success. The tumor was about as large as a walnut. Operation at 9:00 o'clock the same evening. The constriction was very tight. As soon as the ring was out I found there was still some little glistening of the peritoneum. The patient has made a very smooth, uninterrupted recovery.

I report this case more as of interest on account of the advanced age of the patient, and call attention to that feature which the profession generally recognizes—not to delay until very bad symptoms arise, but to operate early.

**DR. C. F. HOOVER**

*Necropsy of a case of Aneurism*

It is not often that one has an opportunity to autopsy a polyclinic patient. An undertaker came to me for a certificate of death in a man who had visited the polyclinic. On looking up the record I found he had been there. This man died on the 23d, and had been at the polyclinic on the 16th. The only record I had made was that he had an emphysema. Both lungs in the axillary line extended to the eleventh rib. There was a temperature

of 100.5 degrees. Nothing more was made out at the time, so, of course, we found it necessary to make a necropsy to fill out the death certificate. In this necropsy we found this aneurism in the descending aorta. The man had an immense emphysema. Both lungs were very grumous, so at first on getting hold of the lungs one would get the impression that he had a very extensive pneumonia. This aneurism had eroded parts of the fifth, sixth and seventh dorsal vertebrae, and the sac stood between the right and left lung. The man had no thrill of aorta, no hypertrophy, no dilatation, no accentuation. He was taken with a very severe fit of coughing, coughed up a little blood and expired.

I learned from the woman afterwards that the man had had difficulty in swallowing for about five months. The left bronchus was considerably compressed. There is a clot in the aneurismal sac. Undoubtedly the man died from compression of the pulmonary veins. It is compression of the pulmonary veins because there was no dilatation or hypertrophy of the right side of his heart. It shows very well the two elements which produced the cough: The irritation of the bronchi and the compression of the pulmonary vein, which increased the tension in the pulmonary circulation.

In aneurism of the aorta we often find the bodies of the vertebrae quite rough. In this case they were quite smooth.

DR. A. F. HOUSE

*Cystosarcoma of the Shoulder*

I have here a tumor. The tumor itself is not so interesting, but perhaps the history of the case may be more so. Thirteen years ago I removed a lipoma about the size of a fetal head from the right side below the lower margin of the scapula of this same patient. Six years ago I removed one, not from the same place but from the same region, that weighed eight pounds, purely lipoma. Today I removed this. This is undoubtedly a cystosarcoma. Portions of it show that it was perhaps at one time a lipoma. Whether it is a degeneration from lipoma into cystosarcoma I am not able to say. There are other small tumors that look like ordinary lipomata. But on section they look more like myxomata. The lady is 65 years of age. The tumor started on the shoulder and ran down over the shoulder and under the arm. A portion of it was under the scapula, so that the scapula was very much displaced.

The patient is in very nice condition. No trouble at all after she came out of the anesthetic.

I would say that recurring and symmetrical lipomata are supposed to be of central origin.

**Program**

DR. J. F. HOBSON read a "Report of a case of Pott's Disease of the Spine."

This will be found on page 367 of this number of the JOURNAL

Report of a Case of Pott's Disease in the discussion of Dr. Hobson's paper, by Dr. William E. Wirt.

MR. PRESIDENT: I have taken great interest in the report of the case of Pott's disease to which we have just listened. It is of much interest to me both from the standpoint of diagnosis and prognosis. The reporter in this

case recently described the case to me, and knowing that the report was to be made to this Society this evening, I took the liberty of bringing before the Society a very similar case of Pott's disease in regard to age, difficulty of diagnosis and prognosis, which will therefore make a good illustration of the case described in the report. The case before you, gentlemen, is a man 45 years of age, who has been suffering from Pott's disease for some months. The case was brought to me by Dr. A. D. Campbell, who had the care of the man from the beginning of his illness, and who will give the early history of the case.

DR. A. D. CAMPBELL read the following history of the case referred to by Dr. Wirt:

Name, T. P.; residence, Cleveland; age, 45 years; nationality, Scotch; occupation, blacksmith; habits, good, total abstainer; weight, 175 pounds; height, five feet, ten inches.

This patient came to me on June 8, 1895, with what appeared to be acute lumbago of nearly two weeks' duration. He had a history of having been compelled to get up every night to urinate for the previous two months, generally three or four times between 11 P. M. and 6 A. M., and many times during the day. Part of the time urine was, he says, very light in color, and large in quantity. Then it would change to darker color and smaller quantity. At one time, two or three months previous, the urine was at times bloody. The specific gravity ranged from 1.022 to 1.026, with color variable. No albumin or sugar. He had noticed pain in his back at times for six months, and upon further reflection said for more than a year, but thought it due to his occupation. He complained of pain and heat at the left sacroiliac junction and also of a cold wave running up and down his back at times during the day. In the morning his feet were slightly swollen and there was a little puffiness under the eyes with skin bluish.

His appetite was good. He had little pain when sitting but could not stoop over very well. Examination of the spine revealed only a painful spot about the size of a silver dollar,  $1\frac{1}{2}$  inches above and  $1\frac{1}{2}$  inches to the left of the coccyx, with sciatic pains running down back part of the thigh, but no painful points in the spinal column.

June 11. He urinated only once last night. Said that his mouth had been very dry and he has been constantly thirsty for some time. He lost 15 pounds in weight recently, but has had no boils for the past five or six years. For past year he has had no sexual desire, but no loss of power.

He improved under ten days' rest in bed with salicylic acid, quinin and antikamnia, but salophen in ten grain doses gave the most satisfaction, with application of liniment externally.

Later, under treatment the mouth and tongue became moist with regular night's rest, without urinating. The reflexes were good, with perhaps an exaggeration of the right knee-jerk. Tremor was marked in the hands and arms, more on the right side than on the left. The patient dragged his left leg and found it very hard to stand with his eyes closed.

At this time there was no appreciable enlargement of the lumbar vertebra. I took the patient to a consultant in August. We also examined him at his home about a week later and found tenderness in lumbar region, but were undecided as to the condition of the bones themselves. After the third examination we applied the actual cautery to the lumbar region and to the painful spot to the left of the coccyx. In about three weeks we touched him

up again. During this time the patient was kept in bed and given sodium salicylate and later potassium iodid. The diagnosis laid between rheumatic spine and irritation of spinal column with, perhaps, involvement of the spinal cord.

He improved for a time under this treatment then relapsed as bad as ever. In October a neurologist was consulted. He was undecided between rheumatic spine and cervical caries. Examination of the eyes by Dr. Bruner gave a negative result.

On November 9, '95, Dr. Wirt found a painful spot in the spine, and also decided that there was enlargement of the second or third lumbar vertebra with spasm of right spinal erector muscle. After a most careful and discriminating examination he pronounced it Pott's disease, since which time the patient has been under his supervision. The temperature was variable, but always above the normal.

DR. W. E. WIRT: The patient first came under my care November 9, 1895, weighing at that time 177 pounds, while his present weight is 198. He had always been quite healthy till within 18 months of my first seeing him, at which time his back began to ache, especially after working hard. The trouble did not follow an injury, nor has it any relation to the weather. He has been gradually getting worse and noticed six months ago (this history is taken from my notes at the time of examination) that he had difficulty in stooping or in buttoning his shoes, which difficulty continues. He picks up a key by sliding down his thighs. There is pain in the sacral region, but no pain elsewhere. The patient claims that his legs ached at one time. He had difficulty in his urinary apparatus at one time, but now there is no such trouble. Examination of his eyes gave negative results. I find a very slight prominence of the second lumbar vertebra with spasm in the lumbar muscles. The knee-jerk on the right side is exaggerated while that on the left side is about normal. The abdominal reflexes appear normal. The patient's temperature is 99.5 degrees. The spine has been cauterized with negative results, and the same may be said of potassium iodid which was used. Salophen has relieved his pain, and some benefit seemed to follow the use of salicylate of soda. The patient standing requires the support of the table or chairs, bearing much of his weight on his hands. In walking he uses two canes and walks with a slow and uncertain gait. In sitting he says he gets much relief by putting his hands on the chair seat and pushing down on it, thereby relieving weight from the spine. Likewise relief is gained by hanging from the door post or transom. My diagnosis from the above history and examination is lumbar Pott's disease. I took the patient before the senior class at the College of Physicians and Surgeons, and, although I told them it was a case of Pott's disease, they were unable, until I pointed out the exact spot, to find the kyphosis, but on the contrary several of the class fancied that there was lordosis. This was the depression which they felt just above the kyphosis. I would here say that lordosis of the spine at the point of disease is impossible from mechanical reasons, which are that the disease is practically always in the bodies of the vertebra, and when deformity does take place, due to destruction of the bodies, the spine must drop forward in the same way that if you would take the foundation walls from the front of a house it would necessarily fall forward and not backwards. This reminds me that had a certain professor of surgery who sent me a patient remembered this mechanical principle he would not have made the mistake



that he did, which was to send me a case of congenital dislocation of both hips, having the usual lordosis, as one of Pott's disease, with the unusual deformity of lordosis. It is true that the books refer to a lordosis found in the lumbar parts, but this is a general compensatory lordosis found above and below the point of disease, but *at the point* of disease, if there is any deformity, it is always a kyphosis.

I did not have an opportunity of treating the patient until January 18, 1896, at which time I applied a plaster-of-Paris jacket. January 31, the patient states that he is much improved and is able to walk without canes. April 3, the patient is much improved and has increased in weight so much that the jacket had to be cut down in front, being too tight. At the present time the patient's weight is 198, being a gain of 21 pounds since I first saw him. [At this point five minutes were allowed for the members of the Society to examine the patient]. As the Society seems to take great interest in these cases of Pott's disease, I will, with your consent, go more thoroughly into the points of differential diagnosis. In some of these cases of Pott's disease, especially in those of the disease occurring in middle life, which is true of the two cases presented by Dr. Hobson and myself, the diagnosis becomes extremely difficult, and it is only by methods of exclusion that the diagnosis can be made out.

By exclusion we have to differentiate between Pott's disease and lumbago, sprain, rheumatism, irritable spine, scoliosis, sarcoma, syphilitic disease of the spine, hysterical spine, sacroiliac disease, hip disease, and congenital dislocation of the hips.

I will only have time to give the major points of differentiation under each heading.

*Lumbago*.—In lumbago the muscular tenderness is too exaggerated for Pott's disease. The spine can be bent though causing pain, while in Pott's disease the spine cannot be bent, but is absolutely rigid. There is no rise of temperature in lumbago, while in Pott's disease this is nearly a constant symptom. In lumbago there are no reflex symptoms and no deformity, while in Pott's disease both of these symptoms usually exist.

*Sprain*.—In sprain there is no rise of temperature; there is no deformity; there are no reflex symptoms; the spine can be bent.

*Rheumatism*.—Varies considerably with the weather, especially in connection with the moisture. This is not true of Pott's disease. In rheumatism there is no deformity of the spine; the spine is flexible and there is no pain on deep pressure; there are no reflex symptoms; the temperature is variable.

*Irritable Spine*.—There is no deformity; the spine is too sensitive on superficial pressure; there is no rise of temperature; the spine is not ordinarily rigid, though in some cases it may be somewhat stiff. Usually there are many reflex symptoms, which the gynecologist, the ophthalmologist and the neurologist are called upon to relieve.

*Scoliosis*.—One hardly expects lateral curvature of the spine to be called Pott's disease, yet I have had such cases sent to me by some of our teachers in medicine under the diagnosis of Pott's disease. In scoliosis the curve is lateral as well as posterior; there is no rise of temperature; the spine is not ordinarily rigid, nor is there usually pain, though sometimes both of these symptoms are quite marked. Usually there are no reflex symptoms; no abscesses occur.

**Sarcoma.**—It is impossible to differentiate between sarcoma and Pott's disease at the time of invasion. In sarcoma the deformity is more rounded and less defined. One has to consider the age of the patient and the progress of the disease, which is usually more rapid in sarcoma.

**Syphilitic Disease of the Spine.**—This is a very rare disease. One must be guided by the clinical history and age of the patient in making the diagnosis.

**Hysterical Spine.**—The subjective symptoms are very much exaggerated. There is no deformity; there is no rise of temperature; there are no abscesses. By very careful manipulation the spine is found not absolutely rigid as in Pott's disease.

**Sacroiliac Disease.**—There is no deformity of the spine; there is pain on lateral pressure of the iliac spines which is not found in Pott's disease; there is a disability in limb of the same side with the diseased sacroiliac articulation without the shortening or atrophy of hip disease; there is no rigidity of the spine.

**Hip Disease.**—There is no kyphosis of the spine; there is no pain in the back; no spinal rigidity, but symptoms are referred to the knee; there may be lordosis of the spine, which leads to the belief that there is something wrong with the spine. But the surgeon should always remember that there is lordosis (local) in Pott's disease.

**Congenital Hip Dislocation.**—There is lordosis without rigidity of the spine; there is no rise of temperature, nor are there any referred symptoms, but the diagnostic point is the relation of the great trochanter to Nèlaton's line (a line drawn from the tuberosity of the ischium to the anterior superior spine) which, in the normal hip, is directly under this line.

**Treatment.**—Just a word in regard to treatment: it may be necessary and often is the very best treatment to keep these patients abed for a while at the beginning or at any time during an acute exacerbation. When doing fairly well they should be up and about, taking light exercise with the spine properly supported. They should not be allowed to do any lifting or heavy work or anything that requires stooping. The question of the proper support is often a difficult problem to decide; braces and jackets are the most common forms of support. Sometimes I have tried plaster jackets, afterwards to learn that my patient could not endure the jacket, and so hunted up the brace-maker and got a brace. Again I have had braces made, and spent hours trying to fit them so that they would be comfortable, only to find that I had to ultimately go back to the jacket, due to the unbearable discomfort of the brace. Abscesses should be aspirated and injected with a ten percent emulsion of olive oil and iodoform. Many members of the American Orthopedic Association deprecate the opening of abscesses from Pott's disease by the knife, as in a large percent of these cases the abscess ultimately becomes septic and bad results follow.

**Prognosis.**—In children the prognosis is good, the mortality in recent years, under active treatment, having been reduced as low as six to eight percent; in adults the prognosis is bad, the mortality being probably as high as 50 percent. In my own experience it has been my misfortune to see over half (nearer two-thirds) of the adult cases die. In Wadsworth, Medina County, I have been called in consultation to see three adults with Pott's disease, all of whom ultimately died. Let me relate one of these cases, which will illustrate the difficulty of diagnosis, the plan of treatment and the

prognosis. Mr. J. A. H., aged 30, was sent to me by his physician, having been treated two years for hip disease. In six months the patient had lost 20 pounds and was badly run down, being barely able to walk by the aid of a cane. The patient limped badly on right side, had pain in thigh and knee; the thigh was drawn up and there was considerable swelling around the right hip and thigh, making an array of symptoms quite apt to lead us to look to the hip as the seat of the disease. On examining the patient carefully, while finding the above symptoms I also found that there was no shortening of the limb nor was there any atrophy of limb, two symptoms that are practically always found after two years of the disease when of moderate severity. On having the patient strip off his shirt and go near the window I found a barely appreciable kyphosis in the region of the third or fourth lumbar vertebra. On aspirating the thigh I withdrew a pint and a half of pus, after which the movements of the thigh were perfect and the symptoms of hip disease disappeared. I put the patient in bed and in three weeks he had gained twenty-one pounds, after which he left the hospital, wearing a jacket and in excellent condition. Within a few weeks he fattened up so much that the jacket had to be cut down in front. I aspirated him a couple of times and applied a new jacket. I warned him that he must do no heavy work, must not lift anything heavy, and must lead a very quiet life; that if he did not follow my directions he would surely die. Soon after he drifted out of my hands into those of a recent graduate. I further learned that he was working around a store, carrying buckets of coal and pails of water, and, in fact, doing heavy work. Soon it was reported that he was again getting worse. The abscess refilling, the young doctor in attendance attempted to aspirate, but, failing, he opened with a knife. The abscess very soon became infected, the patient constantly absorbing pus, rapidly declined, and was obliged to take to his bed, and within a year of my last visit he died from exhaustion. Had he followed my instructions faithfully it is quite possible that he might be living today.

DR. L. B. TUCKERMAN: I have been very much pleased by the frank admission of Professor Wirt that sometimes professors do not know any more than the rest of us. I have suspected such for a number of years, having been at one time myself a professor of some things which I know more about now than I did then.

It is always easy to cuss the first doctor. But the specialist and eminent professor always has this advantage in diagnosis. He has the hind-sights of the first doctors. He has got their diagnosis and time has furnished the proof that their diagnosis is not correct, and he starts with just so much eliminated from the field. We know the protean manifestations of rheumatism; we know that rheumatism may go on to caries; and we know that sometimes people with lumbago have great difficulty in picking up things off the floor; in fact, I think I have seen them go through the motion of sliding down very carefully to pick up things as Dr. Wirt noted that these cases of Pott's disease do. It seems to me possible that Dr. Campbell's diagnosis in the first place may have been right. The disease may have started with a rheumatic inflammation.

I am surprised that I have not seen in the last certificate of the effects of tongaline any mention of Dr. Hobson's case. I hope Dr. Hobson will send it on.

DR. C. F. HOOVER: I think Dr. Wirt has made the early diagnosis of

Pott's disease of the spine easier than it really is. I saw a case where absolutely nothing was to be found to localize.

Another man I recall who had loss of reflexes with pain in the course of the sciatic, which later turned out to be caries. But up to the time the deformity was discovered and the fever occurred, I think diagnosis was absolutely impossible.

**DR. H. J. HERRICK:** This class of symptoms indicates some disturbance of the constitutional condition. In all these cases whatever the difficulty of diagnosis is, we have simply one thing to do; whether the disease is lumbago or rheumatism or Pott's disease of the spine, the proper treatment at the beginning is to confine your patient in bed. Rest is demanded and should be continuously granted until parts are restored. I should like to ask if anyone can give me the formula of tongaline and also of antikamnia. I see it is common for professional gentlemen to use these remedies. I should be glad indeed to be informed as to their ingredients.

**DR. HOBSON:** I do not know that I have anything further to say, more than to place myself right before the members of the Society in regard to tongaline. I do not know what it is. It was prescribed by Dr. Devendorf of Detroit; and while ministers are more prone to give certificates of marvelous cures by these remedies, I fancy Dr. Tuckerman will be disappointed in seeing it in the testimonials.

As to the termination of these cases, and this case in particular, I do not believe this man is permanently cured. I fancy it is simply one of those cases in which there is a cessation of the destructive process for the time being. Some strain or undue pressure brought to bear on the spine will set up the destructive process again, and he will not get off so well the next time. I have cautioned him in regard to undue exercise.

**DR. W. E. WIRT:** I have been asked to say something about the operative treatment—that is, cutting down upon the bone—what the opinion is in that regard. Cutting down upon the abscess and trying to eradicate the sac has not been found very satisfactory. You have the original bone disease still existing. There is going to be a discharge continuing, and a sinus, and it is almost impossible to prevent septic infection. Now the question of going further, of going to the base of the disease, that has also been done. At one time it was seriously recommended in treating Pott's disease, but it has not been found satisfactory. Surgeons are not enthusiastic at all. The American Orthopedic Association does not recommend such measures. They would rather use protective treatment of the spine. Abscesses should be treated conservatively, using injections of iodine and glycerin.

**DR. W. E. WIRT**

*Original Method of Using Dry Heat of High Temperature in Chronic Joint Affections*

This paper will be found on page 355 of this number of the JOURNAL

**Discussion**

**DR. R. M. WOODWARD:** Through the courtesy of my distinguished friend, the essayist, we have had an opportunity of trying this apparatus. I

have not been present personally during the time of its application. I believe it has done the patient some good. He expresses his intention of leaving on Monday. In his sailor language he has expressed his admiration of the apparatus by saying it is "hot stuff."

**DR. ROSENWASSER :** A number of years ago I was a very patient sufferer from sciatic rheumatism, and I can testify to the value of heat in relieving pain. Of course I did not use this apparatus. I used simply flannel-wrapped stone jugs filled with boiling water placed along the limb. The heat thus applied would give me some sleep in the night. Morphin always affected me in an opposite way. I took a great many Turkish baths. The air of the room was 160 degrees. Exposure to heat one half hour. The water in which I then bathed at a temperature of 114 degrees was almost enough to make one faint. I submitted to this treatment daily for almost three weeks. Every time I came out of the baths I felt much easier, but the *effect was only temporary*. Within a few hours the muscles would draw up again, and I must say I did not get any permanent benefit from the treatment. It was only time, and a good long time, and plenty of exercise that finally effected the cure.

**DR. W. E. WIRT :** I would say in regard to the first question that following the use of the heat there is a diminution in the size of the joint, which I consider due to resolution which takes place. And that brings me to Dr. Rosenwasser's proposition. Now, from a temperature of 114 degrees that he was able to stand, you do not get that great change in the circulation and in the perspiration from the local part that you do from these high temperatures. That is the point I make. That we have low temperatures used for long periods, and high temperature used momentarily, but here by my method we get high temperatures used for long periods; with the perspiration becoming enormous; with the activity of the circulation enormously increased, and as a result, resolution taking place.

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### The Cleveland Meeting of the State Society

**T**HOSE members present who attended the last session of the Society held in Cleveland about twenty years ago did not have a very high opinion of the success of that meeting. The attendance was small, and there was not enough papers to fill out a half-day's program. By an almost unanimous vote it was decided to accept the cordial invitation of the Cleveland members, and the 1897 meeting will be under the auspices of the profession of that city. Times have much changed since then. Cleveland is now crowding our neighbor to the southwest for first place in the race of Buckeye cities; the Cleveland Medical Society, with its large membership, has just been made an affiliate of the State organization, and the Society just entering its second half-century has had the two most largely-attended sessions of its history. Judging by the representatives at Columbus, the Cleveland brothers will make excellent hosts and we look for a large attendance at the fifty-second session.—*Columbus Medical Journal*

## Medical News

**Dr. E. G. Carpenter** was recently elected a member of the Tippecanoe Club.

**Dr. Henry A. Becker** has returned from Europe, where he spent over a year in postgraduate work.

**Dr. Howard S. Straight** lectured before the Tri-County Society at Ashtabula on the evening of July 7.

**Dr. C. J. Aldrich** returned from England early in July and went immediately to visit his parents at Spencer, this State.

**Dr. Henry S. Upson** lectured before the medical society of Erie, Pa., on the evening of July 7, stopping off for that purpose while on his way to spend his vacation in the Adirondacks.

An **esteemed** western contemporary is making a habit of clipping news items from the JOURNAL, without giving credit for the same. As our opinion of said contemporary is of the highest, we hope the omissions of credit are inadvertent.

**The Garbage Commission** met, July 7, and decided to at once solicit bids for the establishment of a plant for the destruction of the city's garbage. No discussion of the method of destruction to be employed will be had until the bids are opened.

**The Bulletin** of the American Medical Publishers' Association has grown from a modest beginning to a strong and active publication and is of inestimable value to the medical publisher. A year ago it was an experiment; now its prosperity is assured.

**The State Board** of Medical Registration and Examination met at Columbus on July 7 and succeeding days. A number of "ten-year practice" physicians were examined. The Board by resolution refused to recognize diplomas from the American Eclectic Medical College, the Hygeia Medical College and the American Health College, all of Cincinnati.

**The American Dermatological Association** will meet at the Hot Springs of Virginia, September 8, 9 and 10. A good time is assured. Papers upon interesting topics have already been promised. Dr. White will open a discussion on the subject, "What effect do diet and alcohol have upon the causation and course of the eczematous affections of psoriasis."

**The Laryngoscope** is the title of a new journal published in St. Louis and devoted to diseases of the nose, throat and ear. It is edited by Frank M. Humboldt, M. D., and M. A. Goldstein, M. D. The initial number dated July, 1896, is neat in appearance, and the contents are well-digested. It is safe to say that success is assured the new publication if subsequent issues shall maintain the standard of the first one.

**Dr. W. C. Jacobs** has been re-elected president of the medical staff of the Akron City Hospital. The other officers are: Dr. L. S. Ebright, vice president; Dr. E. S. Underwood, secretary. Dr. Ebright succeeds Dr. E. Hitchcock, and Dr. Underwood succeeds Dr. H. M. Fisher. Dr. D. E. Cranz is the only physician added to the staff. Dr. A. E. Foltz was appointed oculist in the place of Dr. Albert Hoover, deceased.

**The New York Medical Journal**, in its issue of July 11, justly felicitates itself upon its first issue with all its matter set by machine. We congratulate it, while expressing mild surprise that a metropolitan journal should be so late in recognizing the advantages of the typesetting machine. Some months' experience has convinced the JOURNAL that pages printed from machine-set type are the cleanest and neatest possible.

**THE JOHNS HOPKINS REVIEWERS.**—It is a rare pleasure to read the pure science, as presented in the Bulletin of the Johns Hopkins Hospital; even the book reviews, written with a marble pen, are refreshing, but when the reviewer, after tearing into shreds, and with good reason, almost all that an author of a work on *Materia Medica* offers, speaks of morphine as "morphia," then indeed is another of our idols shattered.—*The Pittsburg Medical Review*.

**The fourth triennial** prize of four hundred dollars, under the deed of trust of Mrs. William F. Jenks, will be awarded to the author of the best essay on "The Etiology and Pathology of Diseases of the Endometrium, including the Septic Inflammations of the Puerperium."

The conditions annexed by the founder of this prize are, that the "prize or award must always be for some subject connected with Obstetrics, or the Diseases of Women, or the Diseases of Children," and that "the trustees, under this deed for the time being, can, in their discretion, publish the successful essay, or any paper written upon any subject for which they may offer a reward, provided the income in their hands may, in their judgment, be sufficient for that purpose, and the essay or paper be considered by them worthy of publication. If published, the distribution of said essay shall be entirely under the control of said trustees. In case they do not publish the said essay or paper, it shall be the property of the College of Physicians of Philadelphia."

The prize is open for competition to the whole world, but the essay must be the production of a single person.

The essay, which must be written in the English language, or if in a foreign language, accompanied by an English translation, must be sent to the College of Physicians of Philadelphia, Pennsylvania, U. S. A., before January 1, 1898, addressed to Barton Cooke Hirst, M. D., Chairman of the William F. Jenks Prize Committee.

Each essay must be typewritten, distinguished by a motto, and accompanied by a sealed envelope bearing the same motto and containing the name

and address of the writer. No envelope will be opened except that which accompanies the successful essay.

The Committee will return the unsuccessful essays if reclaimed by their respective writers, or their agents, within one year.

The Committee reserves the right not to make an award if no essay submitted is considered worthy of the prize.

JAMES V. INGHAM,

May 1, 1896.

Secretary of the Trustees.

**Upon a recent** visit to Detroit the JOURNAL, through its representative, was the recipient of much kind attention at the hands of Mr. W. D. Stearns, of the well-known firm of Frederick Stearns & Company, the pioneers in Kola production. The wide range of products manufactured by this firm is a source of great surprise, and their high standing among the medical profession is clearly well-deserved. The quantities of Kola and Wine of Cod Liver Oil, which they are marketing, are almost fabulous, except upon realizing that the whole world is their market.

**Dr. James B. Ford** of Norwalk, died June 27 at the age of almost 70 years. He was an Englishman by birth, though he was brought to this country by his parents when yet a small boy. He graduated from Amherst College in 1854 and from the medical school of the University of Michigan a few years later, having read medicine with Drs. Reed and Sanders. He began practice by entering into a partnership with Dr. Reed, Dr. Sanders having removed to Cleveland, and this partnership continued to the time of his death. Dr. Ford during his long career took a leading part in the affairs of his town, and indeed of the country at large. He was highly respected by his profession and by the whole community, and his death was a great shock to all. Drs. D. D. Benedict, F. Burt, A. L. Osborne and E. J. Goodsell were among the pall-bearers at his interment.

**Dr. C. F. Hoover** has been appointed Visiting Physician to St. Alexis Hospital.

**The new** (fourth triennial) edition of R. L. Polk & Co.'s Medical and Surgical Register of the United States has just been issued and is up to the high standard of the former editions. It is, however, not the present object to review the work, but to direct the attention of physicians, and especially the State Board of Registration and Examination, to some facts made apparent by the directory. The names of 701 physicians are found credited to the city of Cleveland. Of these 417 reported themselves as "regular," 155 reported themselves as homeopaths, 19 wished to be called eclectics, 1 claims to be a "botanic" (species unknown), 1 called himself an electrotherapeutist, 1 was a physio-medical, 2 called themselves "Baunscheidtists," and 105 refused to label themselves. Here is excellent material for the State Board to work upon. To obtain a list of the men (and women),



if any, made to the Board by these 105 professed physicians. If the new medical law is to be worth anything to the profession it must be enforced admitting that they have no medical education, there is needed only a reference to the Register and a comparison of its statements with the returns, along this line.

**Dr. M. J. Love**, of Bloomingville, was in the city July 28.

**Extensive** additions are to be made to St. Alexis Hospital at an early day.

**Dr. E. G. Carpenter** has opened an office with Dr. Welty at 909 Prospect Street.

**Dr. A. B. Howard**, of Cuyahoga Falls, has just returned from several weeks' visit in the east.

**Dr. William H. Humiston** leaves the city with his family, August 8, for several weeks' vacation at the Thousand Islands.

**Sweeping changes** are being made and additional ones are contemplated by the present State administration, in the personnel of the staffs of the various charitable and penal institutions under the control of the State.

**The City Council** persistently refuses to pass a new ordinance to enforce the general use of smoke consumers. The medical profession is directly interested in purifying the atmosphere, and a little judicious work upon its part might cause the Council to see the error of its ways.

**In accordance** with a strongly expressed wish of Mayor Strong of New York, the Commissioners of Charities of that city have set apart two wards in Bellevue Hospital for use in administering a certain secret cure for inebriety. This was done in spite of the indignant protests of the staff.

**The Tippecanoe Club**, of this city, at a recent meeting passed resolutions (by a tie vote and the vote of the presiding officer) requesting the Governor of the State to appoint a Republican superintendent of the Cleveland State Hospital for the Insane in the place of Dr. H. C. Eyman, the present incumbent, who is a Democrat.

**Physicians** of this city are now receiving their certificates of registration from the State Board of Registration and Examination. Appended to each is a notice that the certificate must be recorded with the Probate Judge within 10 days of receipt of the document. No one should neglect this second registration, as its non-performance may lead to a great deal of trouble.

**The medical alcove** in Case Library is well stocked with journals and books, and those who frequent it find a cool and comfortable spot for reading. Every physician should visit it in order to become personally acquainted with its benefits. There being about 200 current medical and pharmaceutical periodicals—both foreign and domestic—kept constantly on file, no one certainly can complain of lack of variety.

**Announcement** is made this month that *Climate and Health*, the valuable publication of the United States Weather Bureau, will be discontinued with the current number (Vol. II., No. 3). This is very much to be regretted, as the systematic correlation of meteorologic data with the phenomena of epidemics, death rates and of disease in general, which has just been so well begun, promised to bring forth in process of time some very valuable facts. Such a work as this can only be done by the general government, as the public and profession would not support such an enterprise upon a scale commensurate with the magnitude and importance of the subject.

The reason for discontinuance of *Climate and Health* is stated to be a doubt as to whether the organic law of the Weather Bureau can be construed to authorize the publication of such a serial. Until this question is settled no more funds will be used for the purpose. It would be well for the medical profession to take some action looking to the specific authorization of this publication by Congress at its coming session. A work of this character will be of very much more benefit to the general public, a benefit increasing with the lapse of time, than any number of reprints of the speeches of our Congressmen, with which the printing office is at present mostly occupied.

### Medical College Statistics

The following statistics, furnished us July 2, 1896, by Dr. Frank Winders, Secretary Ohio State Board of Medical Registration and Examination, will be found of interest to the alumni of the various medical colleges whose graduates are practising in the State of Ohio:

	ORGANIZED.	AGE NO. REGIST. YEARS. ERRED.	
Medical College of Ohio, Cincinnati.....	1819	77	835
Starling Medical College, Columbus.....	1847	49	587
Western Reserve, Cleveland .....	1843	53	516
Eclectic Medical Institute, Cincinnati.....	1845	51	434
Miami Medical College, Cincinnati.....	1852	44	358
Wooster University, Cleveland .....	1863	33	307
Columbus Medical College, Columbus.....	1875	16	244
Cincinnati College of Medicine, Cincinnati.....	1849	47	240
Homeopathic Hospital College, Cleveland.....	1849	47	201
Cleveland Medical College (Homeopathic), Cleveland..	1890	6	129
Ohio Medical University, Columbus.....	1892	4	81

—Cincinnati Lancet-Clinic

## Condensed Table of Mortality in Cleveland for June, 1896

By courtesy of Dr. J. L. Hess, Health Officer

<b>I.—FEVERS.</b>			Hepatitis.....	1
Influenza.....	1		Acute yellow atrophy.....	0
Typhoid.....	10		Abscess of liver.....	3
Measles.....	2		Cirrhosis of liver.....	1
Diphtheria.....	5			65
Varicella.....	0		<b>V.—DISEASES OF CIRCULATORY SYSTEM.</b>	
Intermittent fever.....	0		Dilatation of heart.....	0
Cerebro-spinal.....	1		Fatty degeneration of heart.....	3
Erysipelas.....	0		Rupture of heart.....	0
	19		Endocarditis.....	15
<b>II.—DISEASES OF THE NERVOUS SYSTEM.</b>			Mycocarditis.....	2
Marasmus.....	17		Valvular disease.....	2
Meningitis.....	13		Aneurism.....	1
Softening of brain.....	1		Anemia.....	2
Abscess of brain.....	0		Pyemia.....	1
Apoplexy.....	8		Septicemia.....	5
Epilepsy.....	1		Puerperal fever.....	0
Tumor of brain.....	0		Rheumatism.....	3
Sclerosis of brain.....	1		Rickets.....	0
Aneurism of brain.....	2		Syphilis.....	3
Tetanus.....	1			37
Cerebral embolism.....	2		<b>VI.—URINARY DISEASES.</b>	
Convulsions.....	37		Nephritis.....	13
	83		Acute Bright's disease.....	0
<b>III.—DISEASES OF RESPIRATORY SYSTEM.</b>			Chronic Bright's disease.....	0
Croup.....	1		Cystitis.....	0
Croup—membranous.....	1			13
Bronchitis.....	15		<b>VII.—GENERATIVE SYSTEM.</b>	
Phthisis.....	21		Postpartum hemorrhage.....	1
Pneumonia.....	32		Cancer of breast.....	0
Pleurisy.....	0		Cancer of uterus.....	0
Congestion of the lungs.....	2		Puerperal eclampsia.....	1
Edema of the lungs.....	1			2
Gangrene of the lungs.....	0		<b>VIII.—VIOLENT CAUSES.</b>	
Tuberculosis.....	21		Accident.....	13
Cancer.....	6		Suicide by hanging.....	0
Asthma.....	3		Suicide by shooting.....	0
Whooping cough.....	4		Poisoning.....	3
	107		Homicide.....	2
<b>IV.—DISEASES OF THE DIGESTIVE SYSTEM.</b>			Burns or scalds.....	2
Strangulated hernia.....	1		Railroad injuries.....	5
Gallstone.....	1		Shock.....	1
Gastritis.....	1			26
Cancer of liver.....	0		<b>IX.—UNCLASSIFIED.</b>	
Cancer of stomach.....	2		Inanition.....	30
Enteritis.....	5		Premature birth.....	2
Peritonitis.....	8		Senile debility.....	20
Obstruction of intestines.....	3		Alcoholism.....	2
Diarrhea.....	5			54
Cholera Infantum.....	28			
Enterocolitis.....	6			
Jaundice.....	0			
Total deaths for June, 412. Total deaths for June, 1895, 336.				
Annual death-rate per 1000 during the month (estimated population 330,279) 14.69+				

BUSINESS DEPARTMENT CLEVELAND JOURNAL OF MEDICINE

P. MAXWELL FOSHAY, M. D., BUSINESS MANAGER

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## Delay of Operation as a Factor in the Mortality of Surgical Diseases

BY J. J. BUCHANAN, M. D., PITTSBURG, PA.

*Surgeon to Mercy Hospital*

*Mr. President and Members of The Eastern Ohio Medical Association :*

THE invitation to deliver an address before your Association today has given me profound gratification, for I take it that this is the highest compliment which you, as an Association, can pay to a fellow-practician. This invitation, however, carries with it an obligation that I should say something to you which would repay you for the time consumed, something which would instruct or entertain you; and if I fail in this, then I fail to accomplish the purpose of this address. I cannot hope to present to you today anything that is new or entertaining; but, if I insist on a plan of treatment in any disease, which even one of you knows but does not follow, so that he will hereafter pursue this better course, I will feel that our time has not been lost.

The subject which I have selected for consideration today is "Delay of Operation as a Factor in the Mortality of Surgical Diseases." No reasonable time would suffice for us to consider, even in the briefest manner, all the diseases amenable to surgical treatment which are benefited by prompt operation. I have, therefore, selected certain groups of cases and will take for consideration a few typical examples in each group.

The first group of cases to which I call your attention are those whose origin is an injurious compression of vital organs by non-septic causes.

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*\*An address delivered before the Eastern Ohio Medical Association, July 14, 1896.*

Probably the most common and least debatable of such cases is an ordinary strangulated hernia, and, if it were not so typical of this group, it would seem to be hardly worth while to spend time in its consideration. I presume we will all agree, in a general way, that prompt operation is eminently proper, or, indeed, absolutely necessary, in strangulated hernia.

The injurious constriction of the contents of a hernial sac may be merely sufficient to stop the fecal circulation and check the passage of gas through the portion of bowel in the sac, but may not seriously interfere with the blood-supply of the bowel involved. In this case we have to deal with an *incarcerated* hernia. If the constriction be more severe, or at a later period become more severe, the mesenteric veins of the affected part are compressed, and a condition of venous stasis results. The intestinal wall is filled with blood, becomes thick, dark red or even black. When the circulation is stopped, whether by reason of occlusion of the veins or of both arteries and veins, we have to deal with a *strangulated* hernia. Now, the point which I wish to emphasize is this: that the cause of both these conditions—incarceration and strangulation is the same—a mechanical constriction, and that this constriction may be of any degree, perhaps sufficient at first only to cause an incarceration, but often merging rapidly or slowly into a state of strangulation.

In every case of incarcerated hernia there is some interference with the circulation, and, as this interference tends to increase the constriction, a condition of strangulation always threatens. With a simple incarceration we may safely temporize, but a state of strangulation brooks no delay. Now, is there any means of knowing when the bounds of safety are reached and to what extent the interference with the circulation has gone? I think we may say that a skillful diagnostician will promptly recognize the peril of a patient with complete strangulation; but I also think that if the same skillful man undertake to pronounce on the degree of constriction to which different hernias are subject, and from the history and symptoms to decide which require operation and which may be risked without operation, he will lose many lives which might have been saved by a prompt operation in every case.

The operation itself for the relief of a strangulated hernia is almost devoid of danger. The mortality which attends it is due almost entirely to the condition of the contents of the sac, and the favorable or unfavorable state of these contents depends absolutely, in almost every case, on the promptitude or delay of operation.

Now, if it be true that every case of incarcerated hernia, which is not reducible by a moderate effort of taxis, may be on a more or less rapid way to strangulation or gangrene, and that there is no method of making a diagnosis of the condition of the parts within or a prognosis as to the outcome of the case, and if it be true that the operation is a harmless one, then I hold

it to be my duty and your duty to operate at once on every case of irreducible incarcerated hernia, and not to imperil our patients' lives by delay for the application of cold, the exhibition of morphin and the many other devices in common use, which occasionally serve to kill time till the conditions for reduction become more favorable, but which too often serve to kill the patient as well.

Passing now to the allied conditions of acute intestinal obstruction from internal causes, let me call your attention to the nature of the causes which produce these cases of obstruction. There is *first*, the constriction of a length of bowel by some extraneous cause, such as a fibrous band, the remnant of a previous peritonitis, abnormal attachment of a portion of omentum or an appendix or the margins of an opening in the omentum or mesentery, or many other less common causes. The *second* cause of acute intestinal obstruction which I mention is a volvulus or twist of the bowel itself.

The *third* cause is an intussusception, or the passage of one segment of the bowel into the lumen of the portion next below it.

The *fourth* cause is the sudden closure of a stricture which has previously existed as a chronic condition.

Let us now consider very briefly these four conditions which cause acute intestinal obstruction.

*First*, as to the cases caused by fibrous bands or abnormal attachments of viscera or abnormal openings. We expect them to occur most frequently in young adults and especially in those with a history of previous peritonitis.

The onset is usually sudden, the prostration extreme; accompanied by pain, vomiting and obstipation. Now, it is extremely unfortunate that this condition, as well as volvulus and intussusception should be grouped in the class of intestinal obstructions. It is true that intestinal obstruction is one of the symptoms of all these conditions, but it is also true that the gravity of these cases does not arise from the intestinal obstruction, but from the injurious compression of the bowel, interfering with its vascular and nervous supply.

Many practitioners, when called to these cases, view them merely as cases of intestinal obstruction, and keep pouring in the purgatives till the patients are moribund, without appearing to consider that not only are the grave symptoms not due to the obstruction, but that neither purgatives nor any other drugs can have the slightest effect in removing these mechanical conditions.

*Secondly*, as to the cases of volvulus.

We rarely meet with them earlier than middle life, and usually in persons who have been subject to chronic constipation. Here, also, the onset is sudden and attended with great prostration, severe pain and total obstruction of the bowel. The abdomen becomes immensely distended and peri-

tonitis rapidly supervenes. Vomiting is also present. Neither in these cases nor in the preceding group is any tumor to be felt.

*Thirdly*, as to the cases of intussusception.

Here, again, the onset is sudden and accompanied by great prostration and pain. Vomiting is not always present. A large proportion of cases have diarrhea, and the passage of bloody mucus with tenesmus is the rule. Palpation of the abdomen will usually reveal a tumor formed by the invaginated bowel and often the intussusception can be felt in the rectum.

*Fourthly*, as to the cases of stricture.

These are usually caused by malignant growths and have commonly, but not always, a history of preceding obstinate constipation.

Here the onset of obstruction is more gradual and the prostration, pain and vomiting less severe. Now, I wish to emphatically state that as soon as the diagnosis of one of these four conditions is made an abdominal section should be performed for its relief. The gravity of this operation is due almost solely to delay in its performance. When the bowel has become gangrenous, or a twisted loop has become so bound down by peritonitis as to render the restoration of its integrity impossible, or when an intussusception has been left so long that it cannot be reduced, or when the patient has become moribund from delay, then, indeed, the operation is a very serious one; but, in most cases, by prompt action, these conditions may be prevented and the operation successfully performed.

As another instance of the injurious compression of vital organs by non-septic causes, I direct your attention to intracranial hemorrhage from injury and especially to hemorrhage from rupture of the middle meningeal artery or its branches. Here there may be not even a contusion of the scalp and there may be no fracture of the skull. But there are a few important symptoms for which we should always be on the look-out and in the presence of which we should always operate. The first of these symptoms is the existence of a period of consciousness between the time of the infliction of the injury and the advent of total unconsciousness. This period of consciousness marks the time during which the hemorrhage is taking place and its duration depends on the size of the ruptured vessel. If the vessel ruptured be the middle meningeal or one of its primary branches, this period of consciousness may be but a few minutes; if a very small branch be ruptured, the hemorrhage will be slow and the period of consciousness may be hours or even days. The second symptom to which I direct your attention is a paralysis of the opposite side, which may involve the face, the arm or the leg, or all of these parts. If the hemorrhage be on the left side, aphasia also may result. The operation itself for the removal of the clot and control of the vessel with reasonable precautions, is harmless and those patients who die after operation die not because of it, but in spite of it. Statistics show that of the operated cases, 32 percent die; whereas, of those trusted to nature, 89 per-

cent perish. It is reasonably certain that an earlier operation than has hitherto been practiced would make a yet more favorable showing for the early operative treatment.

The second group of cases which I shall here mention are those caused by the multiplication of pathogenic microorganisms. The essential element in the treatment of these cases is the early removal or drainage of the primary focus of infection. If this focus is left to spread, as it often does with frightful rapidity, deep-seated abscesses, general infection of serous cavities or fatal septicemia or pyemia may result.

As an instance in this class, let me cite a mastoid abscess. The cause of a mastoid abscess is a suppurative *otitis media*, usually an old chronic case. When a patient who has had a "running ear" develops fever, deep-seated pain and tenderness behind the ear, it is almost a certainty that his mastoid cells are affected. If, in addition, there occur redness, swelling and heat over the mastoid with protrusion of the auricle, then it is certain that the infective inflammation has extended to the periosteum. Now, the operation of opening the mastoid cells is a simple and harmless one and if done at an early period is almost sure to prevent any further mischief.

But, if this trifling operation is neglected, a very considerable proportion of such cases go on to meningitis, infection of the lateral sinus or abscess of the brain.

The diagnosis of infection of the mastoid cells is so easy, the operation of opening the mastoid so harmless, the consequences of intracranial infection from neglect of the operation so frequently fatal, that it seems inconceivable that physicians should hesitate or neglect to urge this operation in any case. It is safe to assert that if every patient with a "running ear" or who has had a "running ear" were warned of the symptoms and consequences of mastoid abscess, every such case would be seen by the physician early in its course. It is also safe to assert that if every case of mastoid infection were seen early, attentively observed and promptly operated on, there would be practically no mortality from this cause, whereas it is undoubtedly true that deaths from meningitis, sinus-thrombosis and brain abscess, all sequels of mastoid disease, and all preventable, form a large part of the mortality from intracranial disease and a very respectable percentage of all deaths.

The next subject to which I ask your attention is appendicitis and I know of no other which so nearly concerns each one of us. A very brief word on the anatomy and pathology of the appendix will enable us to better appreciate the supreme importance of an early operation if any is to be performed and also the utter impossibility of saying in a given case at first that no operation will be necessary.

The *appendix vermiformis* is a blind pouch or offshoot from the cecum, having a narrow lumen directly continuous with that of the bowel and with



the same layers in its walls as the bowel itself, namely a serous, a muscular, a submucous and a mucous coat. It is a rudimentary or disappearing and useless organ and is subject to great variation in size and position. It is usually about 3 or 4 inches long and in most cases floats free in the peritoneal cavity, attached by a triangular mesappendix. The arrangement of the blood-supply of the appendix in man is worthy of special notice. It consists of a single terminal artery from which are given off straight branches to supply different segments of the tube.

There is another thing that is worthy of special notice, and that is that the lumen, communicating with that of the intestine may or may not contain pathogenic microorganisms. There is a third fact worth consideration namely, that the free-floating appendices are very subject to kinking and twisting.

Let us now consider what bearing these three facts have upon the production of appendicitis. Any kink, twist or other condition which causes an abnormal pressure on the terminal artery or vein is apt to cause a vascular disturbance of more or less gravity. If the venous current be obstructed, a condition of passive hyperemia results and the consequence of this is an overgrowth of connective tissue in the vessel walls and a hyperplasia of the walls of the appendix itself, both of which consequences end in a lowered vitality of the entire structure. A catarrhal appendicitis is an easy sequence to this condition. If the swollen mucous membrane blocks the outlet, the catarrhal secretion accumulates in the tube and we have a temporarily or permanently distended appendix, exactly analogous to a case of catarrhal salpingitis.

Now, if there happen to be present in the appendix pyogenic organisms of any kind, and the ordinary colon bacillus is a very frequent inhabitant of this death-trap, as it has been so aptly termed, we have an infection of this fluid and an abscess in the lumen of the appendix itself. Further, if the lining mucous membrane be ulcerated, single or multiple abscesses may form in the wall of the appendix. Further still, by infection from these abscesses, without their rupture, or by infection through the lymphatic vessels in the wall of the appendix, a limited plastic peritonitis may arise which may bury the appendix in a mass of adherent intestines.

If the interference with the blood-supply be a thrombosis of the terminal artery, gangrene of a part or all of the appendix will result.

Now these are some of the many things that may happen in a case of appendicitis. But there are others. Before I mention any of the others, let me read the list of these: Catarrhal appendicitis; intrapendiceal abscess; ulcerative appendicitis; interstitial appendiceal abscess, peri-appendicitis with adhesions; gangrene of the appendix. Now let me say that, if an operation be skilfully done when one of these conditions is present, the patient will almost certainly recover. But if the operation be delayed till

the exudate of the surrounding plastic peritonitis has become intensely infected and has broken down into an abscess, the difficulties and danger of the operation have been immensely increased. And further, if the delay has resulted in the rupture of an intra- or an extrapendiceal abscess into the general cavity of the peritoneum, the case will almost certainly prove fatal. If general septic peritonitis arise, as it may, from infection through the wall of a septic appendix without rupture, or from delay in the removal of a gangrenous appendix, the most thorough operation will give but a slight chance of recovery.

The next pathologic condition due to the multiplication of microorganisms, to which I call your attention is acute suppurative osteomyelitis. This is the disease which gives us our cases of necrosis. It is the rule, I think, for the early stages of this disease to be mistaken for rheumatism, and in a disease so grave as this, the error is a very serious one. The disease, as its name implies, is an acute inflammation of the medulla of bone, due to infection of pyogenic organisms, often following a trifling injury. In the early stages the pain is severe and the constitutional excitement high. Nothing abnormal is to be seen over the affected bone; but the tenderness on pressure should at once arouse the suspicion of this disease, especially if the patient be a growing boy. Opening the cavity of the bone with a chisel at this early stage will permit the disinfection of the medulla, relieve the constitutional symptoms, diminish the tendency to necrosis and greatly shorten the course of the disease.

If this operation is neglected or delayed, the pus makes its way to the surface of the bone, loosens the periosteum, and forms a large subperiosteal abscess. Necrosis of a part or all of the bone results and the case, if it do not result fatally, as it sometimes does, drags on for months always, and often for years.

The third class of cases to which I shall refer are those of malignant neoplasms, and especially such as spring from accessible organs. Take, for example, the ordinary cancer of the lip. Here we have a growth which proceeds slowly, is always open to view, can be removed in its early stages not only without danger to life, but even without anesthesia, and after thorough removal, has but slight tendency to recurrence. So potent, however, is the name of cancer that the greatest difficulty is often experienced in securing the consent of patients to the simple operation of excision of an epithelioma of the lip; and it is no uncommon experience to hear of physicians who have for months, or even years, applied this ointment or that caustic in the vain effort to permanently heal the ulcer or destroy the growth till the patient is finally sent for operation with the entire lip destroyed, the lower jaw invaded, the glands below it involved, and the case a hopeless one.

The same can be said in a less degree of cancer of the breast and cancer of the uterus.

The mortality of excising these organs in the early stage of their cancerous degeneration is trifling, and the results of this treatment are much more favorable than are those of the usual plan of delaying operation till the classical symptoms are evident and the widespread involvement of neighboring tissues has rendered operation useless.

To these three groups of cases which I have mentioned, others might be added, such as the presence of foreign bodies in essential organs, stones in the urinary tract, foreign bodies in the air-passages; extravasation of the excretions, from rupture of urethra and the bowel; but time forbids me to go into these subjects in detail.

In conclusion, let me say a word as to our attitude toward patients who are the subjects of these conditions. I am sure that much of the hesitancy of patients to undergo operation is due to their lack of knowledge of the conditions present.

If we were to take our patients more into our confidence, explain any difficulties which may exist in the diagnosis, tell them the tendencies of the disease if left to nature, the effect, if any, to be expected from the administration of drugs and the risk of operative measures—if we were to do this, I am sure that in nearly every case we would meet with a ready compliance with our advice.

On the contrary, what is the common custom? In all these diseases which I have mentioned, and in many kindred ones, we know that it is not uncommon for the physician who is called early in the case to fling away the golden opportunity of an early operation, and to depend solely on the unaided powers of nature for the cure. He gives some medicine, indeed; and just here he wrongs his patient; for he does not always state that the medicine is not intended to influence the course of the disease and has not the slightest power to cure. The patient believes that the medicine is to cure him, and for this reason is not willing to listen to the suggestion of operation. If the patient is cured by the *vis medicatrix naturae*, the doctor is never loath to accept the credit which the patient is always pleased to give to his skilful medication.

We are all to apt to consider operation as the last resort, and I am thoroughly convinced that if our patients knew as well as we do the dangerous tendencies, for instance, of strangulated hernia, intestinal obstruction, suppuration of the mastoid cells and appendicitis, the absolute uselessness of prescribing drugs for the cure of these diseases, the favorable results of early operation and the unfavorable results of late operation, they would in most cases be guided by good advice, and we would be spared the painful necessity of operating for gangrene of the intestines, cerebral abscess and septic peritonitis.

515 Penn Avenue

## Intestinal Obstruction—Some Diagnostic Points and Treatment

BY M. STAMM, M. D., FREMONT

*Professor of Operative Surgery and Clinical Surgery in the Cleveland College  
of Physicians and Surgeons*

THE cardinal symptoms of ileus or intestinal obstruction, such as pain, vomiting (fecal), constipation, tympanites and anuria, have been known for a long time. Very little has been added of late from a pathologic or anatomic standpoint. Our hopes, which were entertained with the advent of the antiseptic era, that with more timely and aggressive methods better light would be thrown upon the subject, which would have a tendency to reduce the mortality, were not realized in the measure we expected. The general practitioner has not changed his method of treatment, and he is still at sea how to meet the various conditions. This is, no doubt, due to the inability of making a correct anatomic diagnosis, or, in other words, to bring certain symptoms into definite relation with the nature and seat of obstruction. What we have so far gained in this line is principally due to experimental science during the last decade.

Some of our textbooks of recent date draw attention to the different forms and location of tympanites. If the latter is general and we can trace the colon on both sides, we may infer that the seat of obstruction is at the lower part of the sigmoid flexure or rectum. If the left hypochondriac region is less distended than the right, we may find the trouble in the transverse colon. If both hypochondria are empty and we find the tympanites in the umbilical region, the seat of obstruction may be expected in the cecum or lower part of the ileum. If the whole abdomen feels empty and there is eructation and tendency to vomit, but no real vomiting, we may look for trouble high up, at the duodenum or near the stomach, (strangulation of some intestinal portion in the foramen of Winslow). If the stomach alone is inflated and the intestines are empty, we may have pyloric obstruction; in such case the symptoms resemble those of cholera in the algid stage, less the diarrhea.

A more definite symptom which refers either to strangulation or ileus in their earliest stages, has been experimentally produced and observed by Schwenninger. It is the circumscribed meteorism located in the strangulated coil where it assumes a fixed or anchored position. This is caused by the impeded circulation in the strangulated portion, and by the putrid decomposition of its contents and want of absorption of the gas. Von Wahl has taken pains to test the clinical value of this symptom, and has reported several

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*Read before the Ohio State Medical Society, May 27, 1896*

cases, proving its great importance in making an early diagnosis and furnishing an indication and guide for operative interference.

To this has been added another symptom by Schlange and Obalinski, which is the increased peristaltic action of the coil above the seat of obstruction. Obalinski, on the strength of these diagnostic factors, saved by operation nine out of 19 cases of torsion of the sigmoid flexure (nearly 50 percent), and thinks that 80 percent might be saved if operated upon before the fourth day. He further adds that if we notice with the above symptoms a metallic sound caused by the thin fluid contained in the distended coil on percussing or shaking it, and we have no vomiting, or only at a late period, we have a typical picture of torsion of the sigmoid flexure. His clinical experience would point to the fact that increased peristaltic action can be more relied upon in single strangulation than local meteorism.

Another symptom which of late has been observed, is the increased excretion of phenol and indican through the kidneys. They are the products of albuminous decomposition and are found more in obstruction of the ileum and in peritonitis; they seem to be absent in obstruction of the colon. Although this phenomenon cannot be accredited as a definite diagnostic factor, it presents some clinical interest and is worthy of further consideration. It is generally our wish to know whether peritonitis has set in or not; here are the absence of peristalsis and borborygmi, inflation of the bowels and rise of temperature, the most reliable symptoms. In circumscribed peritonitis these symptoms are not so pronounced; the intestines are not so fully distended, and there is still slight gurgling and peristaltic motion. But in diffuse peritonitis the distension reaches its utmost capacity, the intestines are as silent as the grave; there is complete paralysis.

The seat of pain may also give us a hint in regard to the location of obstruction by bands. I have noticed this in several cases, especially in a girl 13 years of age, whom I saved last March by an operation. After she was under partial anesthesia she would, on pressure, still evince great pain in the region where I afterwards found a band about one inch in width stretched over the sigmoid flexure. The contour of the colon and its peristaltic action could also be readily seen under complete anesthesia. In ileus the abdomen is generally not so painful on touch, often even relieved on pressure; the patient is not so much afraid of changing his position as in peritonitis, where the slightest touch or movement causes pain. The temperature is generally normal, or even subnormal at the beginning. Exudation of fluid into the abdominal cavity can sometimes be detected after 12 hours in severe strangulation.

The addition of these new clinical phenomena has, of course, not made the diagnosis definite in every individual case, but still they seem to prove of great value in recognizing the seat and nature of obstruction in its early stage.

It may serve a practical purpose to divide obstruction into dynamic and mechanical ileus. We know that besides secretion and absorption the intestines have by virtue of their muscular contraction the power to expel their contents. This contraction may be impeded either through lack of motor force of the intestinal muscles or through some obstacles which may mechanically obstruct their lumen. In the first instance it is designated as dynamic, and the second as mechanical ileus. In dynamic ileus we always have paralysis of some smaller or larger portion of the intestine. In rare cases this may be caused by disturbance of the circulation after resection or herniotomy, embolism of the mesenteric arteries or spinal diseases; more frequently, however, it is caused by peritonitis, acute or chronic, circumscribed or diffuse.

A more varied and complicated picture is presented in mechanical obstruction. We may divide this into ileus by strangulation and by obturation. The former is caused by some bands, diverticle or appendix, which may constrict a portion of the bowel with its mesentery, by some intestinal hernia into a slit of the omentum or mesentery, by torsion or volvulus. Ileus by obturation is caused by foreign bodies in the intestinal canal, *i. e.*, gallstones, tumors, polypi or cancer, also by cicatricial stricture or by kinking above points of adhesion. Some clinical features have to be especially considered in the diagnosis of this condition. (1) Pain is not intense and continual in the initial stages. (2) Collapse is generally absent or much less frequent than in strangulation. (3) The inflated coils and their peristaltic movement can be readily detected at the seat of obstruction in the distended abdomen. Some trouble in connection with the bowels has generally preceded the onset of ileus.

Invagination or intussusception occupies an intermediate position between strangulation and obturation, and in other cases, to gangrene of the bowels. It generally occurs at an early age, and the symptoms of pain, nausea, vomiting, rectal tenesmus, and discharge of blood or mucus from the rectum, come on suddenly. We detect in connection with these symptoms a cylindric tumor in the rectum or abdomen, one pole of which appears to be fixed to the spine, the other is freely movable. If the lumen of the bowel is fully obstructed, we notice also increased peristalsis before symptoms of peritonitis have set in.

I must repeat that the above-described symptoms of obstruction can only be detected in the earlier stage. The necessity, therefore, should be impressed upon the general practitioner to look for them at his first visit just as much as he would examine for hernia at their usual openings. Obalinski has furnished a list of questions that we should have in our minds when we examine a patient with intestinal obstruction. It might be of advantage to append it here.

## I. ANAMNESIS

1. How long is patient sick?
2. Did it come on suddenly?
3. Is it the first time or recurrent; if the latter, how and how often?
4. Whether patient has had typhoid fever, dysentery, peritonitis, chronic constipation, renal or biliary colic?
5. Was it preceded by a cold, traumatism, improper diet or hernia?
6. Whether pain is intermittent or constant?
7. Whether pain in small of back?
8. If a woman, about menstruation and pregnancy?

## II. PHYSICAL EXAMINATION OF PATIENT

9. About pulse and temperature.
10. Strength of patient.
11. Size and shape of abdomen. Whether empty, distended, globe-shaped or regular.
12. Whether contour of anchored coil cannot be detected on the surface.
13. Whether resistant on pressure, or deep tumor.
14. Whether increased peristaltic action.
15. Whether on touch the whole or only some parts of the abdomen are painful.
16. Whether fluid can be detected on percussion in the abdominal cavity.
17. Whether on percussion or shaking we hear a metallic sound.
18. Vomiting, when and how often? Whether feculent.
19. Whether hernia? The whole median line should be examined, as hernia is often overlooked in that region.
20. Whether micturition is normal or disturbed.
21. Whether there is blood or mucus in the rectum and some hard resistant body.
22. Any new condition found during operation should be noted or compared with our former diagnosis.

*Treatment.*—If we succeed in making a correct anatomic diagnosis, we should have no insurmountable difficulty in adopting the proper course of treatment. Internal clinicians claim that so far their mortality in obstruction is not greater from opium treatment than others have with surgical interference. This may be so, but it should not be forgotten that a definite diagnosis of the seat and anatomic nature of obstruction has so far been rarely made, and surgeons have only been called in at a late hour to share with the physician the responsibility of delay or shoulder it themselves alone.

From consideration of the anatomic conditions, as well as experience, we can mention the use of cathartics only to condemn it. In peritonitis

rest of the bowels is, no doubt, the most important factor, and I think no physician would expect benefit from cathartics in hernia or intestinal strangulation. Irrigation of the bowels, with large quantities of water, turpentine, or ox-gall added have never done harm in my hands, and I think very much good in some cases. Over twenty years ago I gave injections to two boys; one had sixteen solid stools within three days, the other 54 stools within 10 days, with peritoneal exudation up to the umbilicus and abscess in the right iliac region. After I detected slight fluctuation I opened the abscess and emptied about one quart of pus, and, therefore, unconsciously operated at that time on a case of appendicitis. I think with rest, diet and small doses of opium, a great many cases of diffuse peritonitis fare well, and even some cases of diffuse peritonitis will recover. If the presence of pus can be diagnosed, an incision in that region, and not in the median, is indicated.

A few weeks ago I was called to see a man about 24 years old, who for ten days presented symptoms of appendicitis. For the last 36 hours he suffered from obstruction of bowels and vomiting. There was dullness in the right iliac region and absence of borborygmi, but especially so to the right of the bladder region, where it was quite painful on touch. In the left iliac region there was slight dullness, some intestinal sound on percussion, and slight gurgling on auscultation could be detected. In the rectum I found an elastic tumor compressing its lumen. I decided to make the incision at the seat of pain and dullness, to the right of the bladder. After incision I worked my finger to the region of the cecum and found about one teaspoonful of pus, but not more; on further examination, working my way then in between the intestines and bladder, I plunged into a cavity from which I emptied over one quart of pus.

In cases of obstinate vomiting, lavage of the stomach promises great relief. In April, 1878, I used this method in a case of obstruction high up, where vomiting was almost incessant for several days; the effect was like magic and the patient improved immediately. I do not mention this as a claim of priority, since I have never published the case, thinking it might have been a mere coincidence. Moreover I was not as fortunate in having a second case in rapid succession to verify the result as had Prof. Kussmaul, who, six years later, published the report of two cases which were made ready for operation, and to clean the stomach were submitted to lavage, which gave immediate and permanent relief. The only objection to this method is, that in some cases it may only have temporary effect and lull us into false security, which might induce us to let the best time for an operation pass by. In regard to diet, iced milk with a little brandy, or small doses of champagne may be given at longer or shorter intervals; for thirst, small pieces of ice, saturated with brandy.



Where the heart begins to fail, and to cover the great loss of fluids from the tissues, infusion of salt water often proves of great benefit.

Where meteorism becomes so intense as to call for interference, puncture of the bowels with a hypodermic or aspirator needle has been recommended. In a case about twelve years ago, where the abdomen was enormously distended after about two weeks of obstruction, I introduced an aspirator needle into the ascending colon, ostensibly for the purpose of inducing euthanasia, but with the result that the patient has been in the best of health ever since.

In cases where we are afraid that the contents of the bowels might escape through a puncture opening, the establishing of a fistula would not be more dangerous, but, no doubt, of greater advantage. Where we have a patient who is taken with sudden pain in his bowels and feels very sick, with the general signs of obstruction, we should look for local meteorism and increased peristalsis. If the distended coil is large and visible, very little doubt can exist as to its being a case of strangulation or volvulus, and we should resort to laparotomy at once. Where only a small coil is incarcerated or where the seat is more toward the spine, or down in the pelvis, so that it cannot readily be palpated, it should be watched very carefully, sometimes for days, and as soon as increased peristalsis or local meteorism can be detected, be operated on at once. Here we must be especially careful not to obscure the symptoms by the indiscriminate use of opium. If we overlook the above symptoms, and allow the case to go on we will in due time find the symptoms of diffuse intestinal paralysis or peritonitis developed, where then we had better abstain from any severe operative measure. Where there is already considerable distension of the abdomen, but you can still detect some coil on careful palpation and peristaltic action on percussion, so as to enable you to get promptly at the seat of obstruction, operation is justified. This step is very much shortened by looking for the empty coil below the constriction, and, in case of necessity, the bowels may be everted.

In case of volvulus, local meteorism is a very important symptom. Obalinski says that we generally find a dome-shaped prominence about two to four inches long and about the same width which on percussion gives a tympanic sound, is resistant to touch and becomes more visible during a seizure of pain. If to this is added the metallic sound, and there is no vomiting or only at a late period, we have the characteristic picture of torsion of the sigmoid flexure. Operation in volvulus should not be delayed very long. In some cases it may be necessary to puncture the intestine or make an incision to empty its contents before we succeed in reducing it. The question how to prevent its recurrence should also engage the surgeon's attention. Senn's method of shortening the mesentery by folding it upon itself in a direction parallel to the bowel, and maintaining it in this position by a few cat-

gut sutures, has proved of practical value in his hands. Roux of Lausanne has in two cases stitched the mesentery near the intestine to the parietal peritoneum. Some surgeons have even resorted to resection of the intractable coil.

In obturation our steps have to be guided by the existing cause and condition. If a foreign body causes the obstruction, its extraction by incision would be the proper procedure. In case of stricture, anastomosis or resection is indicated. About six years ago I made an anastomosis with my cartilage plates for traumatic stricture of the ileum, in a boy seven years old, with good permanent result. (*Medical News*, Jan. 10, 1891). If due to compression by a tumor enterotomy or resection are the preferable methods. Last summer I operated at a very late period (three weeks) on a case where the colon and abdomen were enormously distended. A retroflexion of the uterus prevented me from examining the lower part of the bowels; I was, therefore, not positive whether it might be the principal or sole cause of obstruction. I hesitated between making an incision in the median line or in the right iliac region, where, if need should be, I might establish an artificial anus at once, but finally I decided for the median line. After the incision was made the bowels forced themselves violently through the opening and were so brittle that they tore in four places, so that I was obliged to make a resection. On reaching the pelvis I found a circular cancer of the colon tied down to the promontory, the uterus below acting as a ball-valve. The patient was so exhausted that she died about ten hours after operation. Could I have foreseen the true condition I would have made an inguinal colotomy, but I did not find the glassy mucus in the rectum which Schlangé considers a characteristic sign of cancer of the rectum or colon.

In cases where there is some doubt about the nature and seat of obstruction, enterotomy or a fecal fistula would hold out the best temporary hope. In intussusception or invagination we may at first try injection of large quantities of water in the genupectoral position or insufflation of air into the rectum. If the invagination is low down, massage by sponges attached to a probe, or the finger alone may be employed for its reduction. Should all this prove of no avail, disinvagination by laparotomy will have to be attempted, and where this method fails or where gangrene is already present, resection would be the only expedient. The method of Miculicz seems to me to present special advantages in such cases.

## An Unusual Case of Extreme Flexion of the Head of Doubtful Causation

BY T. W. JACKSON, M. D., AKRON

*Physician and Surgeon to the Summit County Infirmary, Akron, Ohio*

THE case which I report to you today is one of considerable interest from the standpoint of diagnosis, and it is with the hope of obtaining valuable suggestions that I submit it to your consideration. Briefly this is the case:

Six months ago the patient, M. C., an unmarried female, native of the United States, aged 41, came under my care at the Summit County Hospital. The following points of her history were obtained from her, and in part corroborated by her former medical attendant, Dr. S. J. Wright of Tallmadge. Family history negative. Her father died at the age of 75 in a distant place. The cause of his death is unknown. Her mother died at the age of 65 years from an attack of influenza. The patient has two brothers and one sister living and in good health.

During childhood and later, the patient had the following disorders: Scarletina, malarial and typhoid fevers. From each of these affections she appears to have recovered completely. The patient is a large-framed woman, would measure about five feet, eight inches if erect, and four years ago weighed 235 pounds. Her present weight is 166 pounds. From Dr. Wright I learn that she has never been of more than average intelligence, but she is by no means foolish.

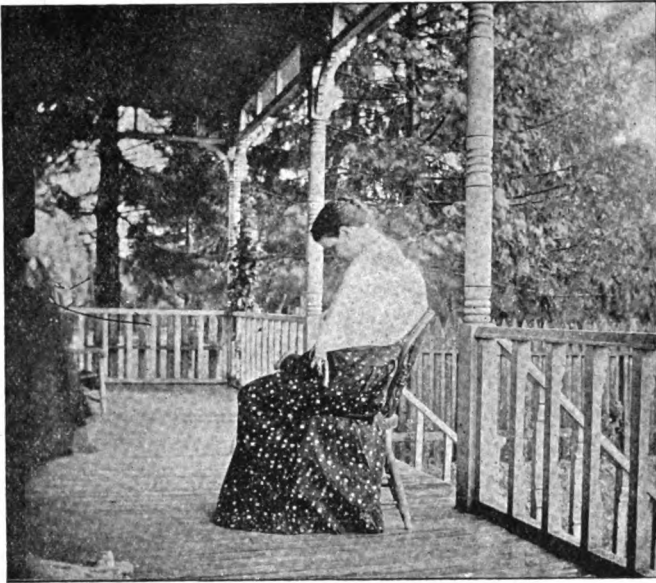
When admitted to the hospital six months ago she presented much the same appearance she now presents, and so far as I am able to judge, she has changed very little physically. Her mental condition seems to be slightly improved, *i. e.*, she is less melancholy, engages daily in light work, and seems happier; whereas, six months ago she was disinclined to mingle with the other patients, claimed to be unable to engage in any employment, and was silent and inclined to solitude.

Upon admission she presented, and now presents, the following curious condition:

The head is flexed completely upon the chest, the chin practically resting upon the sternum. It would be difficult to produce a greater degree of flexion of the head in the cadaver than exists in this woman. It is impossible to produce the slightest degree of extension or lateral movement. At the back of the neck is to be observed an enlargement, an apparent swelling or induration, extending from the seventh cervical vertebra to the base

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*Read before Union Medical Association of Northeastern Ohio, at Canton Meeting, June 9, 1896.*



of the skull and laterally to within perhaps an inch of the anterior borders of the sterno-cleido-mastoid muscles of both sides. This induration is symmetrical and unyielding, having about the resistance of cartilage. The skin covering this indurated area is apparently normal in all respects. In color it is normal and it is freely movable over the entire neck. Fine hairs are present and I have observed sweating on several occasions. The electric condition of the muscles has not been tested. So far as I am able to judge by incomplete tests, the senses of taste, smell and hearing are perfectly normal. I am unable to give a report upon the visual powers and eye-ground at this time. The patient cannot see an object placed at any point above the level of the superior orbital border because of the extreme flexion of her head. The pupils are even and respond normally to light and accommodation. There is present external strabismus of the right eye, which, I am informed, has existed since infancy. There is no strabismus of the left eye. Sight seems to be normal so far as I am able to judge without a proper examination. The knee-jerks are normal and equal. No ankle clonus present. Sensation seems to be fair at all points of the body, and I could find no areas of anesthesia or hyperesthesia. Menstruation was normally established at the age of fifteen, and the menstrual function has been practically normal since that time. At present the menses are somewhat irregular, occurring at intervals of from three to five weeks and lasting from one and one-half days to five days. Vaginal examination negative. The urine is normal in amount, pale, specific gravity 1.015. No sugar, no albumin.

The appetite is somewhat capricious and a tendency to constipation exists. She complains from time to time of dizziness, lasting from five to ten minutes.

In brief, then, we have to consider the abnormalities of the extreme flexion of the head and the indurated tumor-like condition at the back of the neck. The first impression is that the condition we have here is a surgical one, due perhaps to disease or partial dislocation of the vertebra. But consideration of the character of the induration, duration of the trouble and mode of onset makes this supposition less probable. There is nothing in the character of the swelling to indicate inflammation. There is no tenderness, no redness, no fluctuation. The condition remains practically unchanged. There are none of the evidences of disease of the vertebra. The mode of onset scarcely permits us to consider dislocation, and it is impossible for me to conceive of any dislocation, complete or partial, at this point without great damage to the cord. We are, therefore, brought to the consideration of muscular action as a cause of this condition of extreme flexion and fixation. And right here it seems proper to relate the mode of onset of the trouble. One year ago (May, 1895,) the patient retired one night in apparently good health. She awoke, as she supposed, with an ordinary stiff neck, and since that time her head has remained completely fixed. She is of the opinion that the induration at the back of the neck developed gradually, but upon this point she is uncertain. The chief muscles concerned in flexing the head are three pairs: the sterno-cleido-mastoid muscles, the *rectus-capitus-anticus-major* muscles and the *rectus-capitus-anticus-minor* muscles. These are assisted somewhat by the three pairs of *scaleni* muscles, *anticus*, *medius* and *posticus*, whose function it is to flex the neck laterally. The four *recti* muscles arise from the transverse processes of the cervical vertebra and from the atlas, and are all inserted into the basilar process of the occipital bone. These muscles are all innervated from the deep cervical plexus of spinal nerves, and from the third occipital nerve. The sterno-cleido-mastoid muscles are innervated chiefly from quite a different source, viz.:—the spinal accessory nerves, or the eleventh pair of cranial origin. Most interesting also is the fact that in this patient the sterno-cleido-mastoid muscles are completely relaxed. With these facts before us, is it not permissible for us to attribute this condition of flexion to the powerful contraction of the remaining flexor muscles, all of which are inserted into the basilar process of the occipital bone, and all of which have a common nerve-supply, viz.: branches of the deep cervical plexus?

Conceding this, is it not rational to look for some local focus of irritation, impinging, perhaps, at some point upon the deep cervical plexus, and might not this same irritation or lesion account in some manner less easily explained, perhaps, for the dystrophic condition in the posterior region of the neck?

The thyroid gland is apparently neither increased nor diminished in size. Another possibility to be borne in mind is that this condition is one of the countless manifestations of hysteria. Many cases of hysterical contractures are recorded by writers upon hysteria, and almost any group of voluntary muscles may be involved. These contractures persist for many months and even years, but disappear during deep sleep or ether or chloroform-narcosis. In this case the condition is unchanged during sleep, necessitating her lying invariably upon her side. I purpose giving her an anesthetic to clear up the question of hysteria. I must confess that at times her demeanor suggests hysteria rather strongly. Inunctions of ichthyol, massage and the internal administration of the iodids, arsenic and other so-called alteratives, have failed completely to make any impression upon the condition.

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## Puerperal Eclampsia

And Veratrum Viride as an Agent in its Treatment

BY M. M. BAUER, M. D., LAKE

CASE I. Mrs. J. K., aged 17½, primipara, at about full term was seized, without premonition, with a convulsion at 10 A. M., September 26, '95. She at once became unconscious, and one convulsion followed another in rapid succession, averaging, I was informed, four attacks every hour for six hours, until I saw her at 4 P. M. I had no intimation as to the nature of the case I was called to see until a hasty glimpse of the surrounding friends and the patient herself gave the clue that something serious was pending. Just as I entered the room occupied by the patient, and before a word was spoken, she had another attack of frightening severity. This, I was told, was the most severe and prolonged of all. A hasty examination of the abdomen revealed a tumor, evidently a gravid uterus at about full term. The full, quick pulse, that fairly snapped, giving the impression under the finger as being ready to explode upon the slightest compression, rate from 80 to 90, the general arterial excitement and nervous phenomena, all exactly fitted the classical description of puerperal eclampsia.

Decided action was imperatively demanded. I quickly injected fifteen drops of Norwood's tincture of veratrum viride. The pulse at once softened and arterial tension abated somewhat. In fifteen or twenty minutes she had another convulsion. The duration and severity as compared with the one before seemed less marked. About five or six minims more of the veratrum

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*Read before the Union Medical Association of Northeastern Ohio at Canton, June 9, 1896.*

was injected within thirty minutes after the first dose. She had one more convulsion two and one-half hours after I first saw her, or two in all after the initial dose of veratrum.

Further examination revealed a dilatable os slightly dilated. Recognizing the gravity of the case I demanded that assistance be sent for. In the meantime I attempted to enhance dilatation as best I could with the fingers, in order that delivery should be accomplished as soon as possible. Dr. R., on his arrival, concurred in the management, and, when dilatation had advanced sufficiently, forceps were applied without much difficulty and delivery accomplished of a stillborn child, evidently at full term. Efforts at resuscitation were fruitless. The third stage was completed without delay. The patient was put in as good condition as possible, and some hours later was left for the night, with the prognosis in doubt, though hopeful.

I used a catheter at my visit in the morning, and drew off several ounces of urine, which proved to be nearly one-half albumin. It is sufficient to say that she passed rapidly and favorably into convalescence. The kidneys soon acquired their normal functions and albumin practically disappeared within a fortnight. Medication mainly consisted of Basham's mixture supplemented by appropriate diet and systemic tonics. For two days we used hot water uterine and vaginal injections with bichlorid 1-5000. Consciousness gradually returned and on the fourth day she had fully recovered all the faculties of her mind.

Case II. Mrs. F. K., aged 39, occurred in the practice of Dr. Dougherty, of Greentown, September 30, '95. Mrs. K. was at about the eighth month of her second pregnancy, the first having terminated at full term in an uneventful manner about fourteen years before.

In the early months of her pregnancy she had an attack of rheumatism, accompanied by heart and kidney trouble, that nearly proved fatal. She never fully recovered, and throughout the summer she was a continual source of anxiety to her friends and physician. She, however, managed to oversee and attend to her household duties, being the thrifty housewife of an industrious farmer, until on the evening of September 20, '95, at 11 P. M., she was seized with a convulsive attack. Her physician was hastily summoned. He was not at all surprised at the outbreak. I was summoned to assist. Rapid delivery was decided upon and accomplished without much difficulty within four hours of her first convulsion. She had one or two convulsions in the meantime, and received fifteen minims of veratrum subcutaneously, followed within an hour by a second dose of five or six minims. Her circulation was fairly good and mind comparatively clear, so that she replied intelligently to simple questions. She was delivered of a male child of good proportions at about the eighth month, which lived about thirty hours.

Everything now apparently betokened a favorable termination. We remained with her six hours or more, and returned home leaving her in as good condition as possible, and with the hope that she had passed the worst.

The pulse was comparatively soft yet full, though giving no evidence of arterial excitement or increased pressure. The mental condition was clearing. The stomach was somewhat irritable from the large doses of veratrum. Altogether she was as well, if not better, than could be expected from her history of nephritis, with its attendant edema and dropsy which annoyed her all these months. We were again hastily summoned a few hours later, after a return of the convulsions in an aggravated form which, in about twelve hours after her delivery, terminated fatally—asphyxia and exhaustion. In all she had six or seven convulsions.

To me these two cases were full of interest, occurring, as they did, within three or four days of each other, and having only a few points in common. Case I gave a history of dropsy and edema of the extremities in the later months of pregnancy, and was seized with the sthenic form of convulsions, if the term is admissible, which continued almost without interruption, and with increasing severity for more than six hours, and promptly yielded to vigorous doses of veratrum viride. The mental faculties were completely obtunded for four days; the kidneys rapidly assumed their normal condition, at least so far as chemic tests demonstrated, and a general convalescence went on from the termination of pregnancy at full term in an uneventful career. Altogether the case looked very unpromising from the start. Case II gave a history of rheumatism with endocarditis, followed by nephritis, dropsy and edema, labor setting in at about the eighth month with a convulsion of an apparently milder type; at any rate the arterial excitement was not so marked; the convulsions were not so violent; consciousness returned in part after the convulsions, except the last one, there being but six or seven, about fourteen hours intervening between the first and the beginning of the last one, death ensuing from asphyxia in about fifteen or sixteen hours after the first attack. I am satisfied that in this case veratrum had a modifying influence.

The maternal mortality of eclampsia is stated by Parvin in the American System of Obstetrics to be about 30 percent—a fairly conservative statement, death resulting from coma, apoplexy, asphyxia, meningitis and exhaustion. The frightful aspect and the suddenness of the attacks have excited interest in the study of this disease. The uncertain state of exact knowledge concerning its etiology, which it is not my purpose to discuss, is an apology for the various methods of treatment which prevail and have prevailed among obstetricians. Diaphoresis and cathartics, venesection, morphin, chloral and potassium bromid, chloroform, pilocarpin, and many other remedies, have had their firm advocates, and yet the mortality is about the same. Perhaps morphin and chloral are the most reliable of those mentioned above.

Veratrum viride, in large doses from 10 to 12 minims, preferably hypodermically, is said to be distinctly an American practice. Dr. Herbert Fearn, of Brooklyn, in 1871 reported thirteen cases treated with veratrum in very large doses without a death. Later, Rushmore and Jewett, of Brook-



lyn, Oatham of Cantornia, and Reamy of Cincinnati, collected series of cases and called attention to the great value of this drug in the treatment of eclampsia. The dosage should be large, the state and condition of the pulse being the guide. Jewett says, "experience seems to justify the statement that no convulsions will occur while the patient is sufficiently under veratrum to hold the cardiac pulsations below sixty per minute." The initial dose can safely be from 10 to 20 minims, followed in thirty minutes or an hour, if necessary, by a smaller dose of from five to eight minims.

The editorial writer in the *American Medico-Surgical Bulletin* recently said: "It lessens arterial tension by its action on the cardiac muscle and by vasomotor paralysis, and it also produces diaphoresis and diuresis, the latter probably by overcoming the vasomotor spasm of the renal vessels. By so doing the convulsive attacks are held in check and the mortality of this dread disease thus lessened, as the mortality increases directly in proportion to the number of convulsions. It is a valuable aid to whatever means may be employed in the treatment of puerperal eclampsia."

## Report of a Case of Ectopic Pregnancy (Abdominal) in a Heifer

BY C. A. GARRISON, V. S., RAVENNA

On May 25, 1896, I was called to Freedom, a small station on the Erie Railroad, about eight or ten miles from this city, to attend a cow in labor. It was a Jersey heifer about 20 months old, of ordinary size. I found her suffering from abnormal labor, pains occurring at intervals of 20 to 30 minutes. The pains differed from any I had ever witnessed, inasmuch as there was a concave instead of a convex position of the spine, while the pains lasted. During each pain the spinal column was depressed instead of arched, as it is in normal labor. The tail was raised during the pains. The cow suffered severely for a space of two or three minutes, and then was quiet for a short time.

I made a vaginal examination and found the uterus not impregnated and in a perfectly healthy condition. I also found a closed cavity which could be easily outlined or explored by introducing the arm about 18 inches. I found no exit that would admit of the insertion of a finger. I called Dr. Sloan, the resident physician of the town and a physician of ability of 15 or 20 years' experience, who very kindly came to my assistance and made a careful examination of the case, agreeing with me that it was a case of abdominal extrauterine pregnancy. The cow having gone her full term of nine months, it was evident that it was not tubal or ovarian. She had been in labor 48 hours or more, and peritonitis being well established, we thought it not advisable to make the Caesarean operation. We therefore destroyed the animal and removed the calf from the peritoneal cavity. The abdominal or artificial womb was lying well forward in the cavity on the lower wall of the abdomen, which we would naturally expect. There were no adhesions to the surrounding parts and the thing was easily rolled out. The womb or sac was very vascular; contained a limited number of cotyledons and diminutive membranes. The calf was very large and was lying doubled, so that the head was between the hind legs. The vulva of the cow was shrunken instead of being enlarged, as is usual. There was a large amount of fluid in the peritoneal cavity.

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## EDITORIAL

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### Is Constipation Ever a Disease?

CONSTIPATION has been very properly regarded by medical writers as a symptom of disease of the alimentary canal, or sometimes of the nervous system.

The question arises, however, from clinical experience as to whether it may not at times be a disease *per se*. This is suggested by cases such as the following, which are by no means infrequent. A person gives a history of repeated attacks of indigestion with the ordinary symptoms of diarrhea, nausea, pain in the abdomen, etc., preceded a day or so by sluggishness of the bowels or, perhaps, entire cessation of peristalsis. It has usually been said that the preliminary constipation was the first symptom of irritation of the alimentary canal. Attacks of this kind are caused by eating articles usually classed as indigestible, by overeating, or by eating articles which an idiosyncrasy renders improper. The treatment most used is to cleanse the alimen-

tary canal at once by free purgation, this aiding the natural tendency, and then to administer emollients and antiseptics.

At the same time we know that, if constipation arises in the course of organic disease of the spine, for instance, after a day or two it is followed as a rule by free diarrhea and, in general, symptoms much similar to those which accompany the disturbances caused by faulty nutrition, as noted above. Furthermore, observation shows that if *cascara sagrada*, a true tonic laxative, be used in small doses by the person predisposed to the attacks of indigestion, so as to insure free movement of the bowels every day, the attacks will not occur, or at least very rarely.

To such an extent is this true that some patients can partake with impunity of the articles for which they have an idiosyncrasy, provided they use the laxative simultaneously.

These facts seem to render the conclusion clear that constipation may frequently be the primary disease, while the diarrhea, pain etc., are merely incident to the irritation caused by the retained feces.

The further conclusion would also seem inevitable, though by no means novel, that certain articles of diet are of themselves directly constipating and produce more or less serious disturbance of indigestion, unless accompanied by a laxative drug or article of food which overcomes the constipating tendency. If the above method of reasoning is correct, and the conclusions are properly drawn, our cases of recurring dyspepsia should be restudied to see if any of them may not be permanently relieved by the method suggested.

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### Politics and the Insane

SOME weeks ago the Tippecanoe Club of Cleveland passed a resolution that certain changes should be made in the management of the State Hospital at Newburgh. The Tippecanoe Club is a political organization pure and simple. It did not even suggest that changes were needed in the State Hospital, that its inmates would be benefited in any way, that the interests of the people would be better served. When the insane, blind and deaf in our institutions are made the spoils of office it is customary to gloss over the fact with some pleasing fiction. It comes somewhat as a shock to the feelings that these wards of the State should be openly handed over as the price of service and reward of victory. It is perhaps too much to hope that changes should

be made in our State Hospital so as really to benefit their inmates, while they are the shuttle-cock of the great political parties. In fact, removing them from the aegis of the politicians is the one change which would ensure permanence to any regime, good, bad or indifferent. There are, however, some ways in which our insane might be better cared for than at present which are worth considering even under the present somewhat discouraging circumstances. It is well to have, as at present, a medical superintendent as manager of such an institution. The man who is responsible for the food and clothing, the air and exercise of the insane has need of as good a medical training as do those who minister to them sleeping potions and aperients. Thorough medical training and executive ability are rare as combined in one man, they make the successful practitioner, and they are absolutely necessary qualities for the head of a large institution. A good salary will get a good man. He should have under him enough resident physicians to examine and care for every patient every day. That nine to twelve hundred patients can be really attended to by the present force of three or four assistants is out of the question. So much for the routine care of these patients; the conditions of their duration have been revolutionized since the days of Esquirol so that they no longer grovel like convicts in a dungeon, or like hogs in a pen. It is time for another revolution, to correspond with the enormous advances of our knowledge in all branches of medicine and surgery. Modern medicine can only be made of avail in our asylums in one way, by the appointment of consultants in every branch. It is everyday more manifest that even the technic of the various instruments and appliances used in diagnosis and in treatment is too much for one man to master. Surely the insane suffer as much, often much more than the sane from the various ills of the flesh. Even aside from the organic disturbances that in many cases unhinge the mind, brain disorders do not inhibit diseases of other organs. A thorough canvass of any large asylum will unearth a large assortment of displaced wombs, inflamed stomachs, bad eyes and enlarged turbinates. The close study of these cases would not only benefit those afflicted in mind and body but would throw a flood of light on the toxic and reflex causes of insanity. That the plan is a feasible one is too obvious to be stated; that it is a good one is shown by the records of every really well managed hospital; that it is inexpensive is probably the only argument of avail with the sages at Columbus; they should hasten to avail themselves of one of those rare occasions when the best plan is also the cheapest.

## Modern Medical Advertising

WE reprint below a letter recently received by the JOURNAL, and as all of it except the address was printed, it is reasonable to suppose that other journals and physicians received a copy. The letter was accompanied by an "Advance Reprint," (to appear August 15), from the *Journal of the American Medical Association*. In addition to the reprint there was also an abstract of the article nicely arranged for the convenience of the editor in case he had not space to print the article entire.

As the author's paper appeared under such unquestionable ethical authority, we shall have to ask pardon for the presumption of designating the matter as "advertising." All this, of course, apart from any discussion of the merits of the method of treatment of tuberculosis, which the author has devised.

St. Louis, August 10, 1896.

Dr. P. M. Foshay, Editor Cleveland Journal of Medicine, Cleveland, Ohio.

My Dear Doctor:—I take the liberty of sending you advance reprint of "The Experience of Several Physicians with Sero-Therapy in Tuberculosis, Report of Cases," a paper which I had the honor of delivering on May 7 before the American Medical Association, at Atlanta, Ga. This contribution will appear in the *Journal of the American Medical Association*, probably in its issue of the week of August 15, 1896.

"Make haste slowly" has been my motto, and, having now thoroughly tested this antitoxin for a long period of time, and demonstrated its efficacy in proper cases, I feel that my humble labor shall prove useful. I beg you to consider the results obtained, and if you should think them of such interest to your readers that you could comment upon them, or use the article, or the abstract, both of which are enclosed, I would be under great obligations. It is needless to say that I only desire the attention of the profession as to the scientific facts I have stated and assertions I have made on the subject of Sero-Therapy in Tuberculosis.

With sentiments of the highest consideration,

Faithfully yours,

PAUL PAQUIN.

Comment is really unnecessary. The closing paragraph of the letter shows conclusively that Dr. Paquin goes to the trouble and expense of sending this paper to the medical journals and profession solely by reason of his great scientific interest in his subject, and with no thought whatever for the sale of his serum at so much a drachm, which he wisely retains in his own hands to prevent inferior articles being placed upon the market.

### The Heat and the Innocents

THE unusually long hot wave in August developed one fact of extreme interest; during the two hottest weeks the mortality among the children of New York which for some time has been falling, continued to decrease. Of 768 deaths 130, or less than 17 percent were of children, while the rate among children has sometimes been as high as 35 percent. Such a showing in the withering heat of those memorable two weeks, when in a single day 177 were prostrated by heat in and around New York is not without a reason. The *Tribune* ascribes it to the supplying of sterilized milk free to the poor of the tenement-house districts. The *Outlook* adds the construction of asphalt pavements in those parts of the city. While asphalt pavements are much cleaner than the filth-catching and germ-breeding stone pavements with which Cleveland as well as New York abounds, milk supply is without doubt the determining factor in infant mortality. Extreme cold weather is disastrous especially to the aged. Active workers who must toil in the sun furnish a large proportion of those prostrated by great heat but with an adequate supply of comparatively germ-free food there is no reason why heat and cold may not be robbed of their terrors for the children even of those who swelter the summer through in brick walls.

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### Official Check

WE are in receipt of a somewhat remarkable communication from the Treasurer of the American Medical Association. He asks for five dollars as our dues to the Association for 1896. Considering that the members of the Cleveland Medical Society are now suspended, on a most unjust charge and even without the formality of a hearing this might, as a sample of impudence be taken as the most gigantic product of the nineteenth century. It is not however probable that the sober sense of the American Medical Association would sanction the assessment of its former members for the honor of suspension from their organization. This bit of horse-play is probably the result of the scheme which was railroaded through the Association at its Atlanta meeting and which will undoubtedly be repudiated next year on the earliest possible occasion. The Cleveland Medical Society has none but the friendliest feelings for the American Medical Association as a scientific body. It is

unfortunate that the scientific members have so small a part in the workings of the organization.

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It is with pleasure that we present to our readers this month two surgical papers which practically complement each other—Dr. Stamm's and Dr. Buchanan's. These papers are worthy of the most careful attention on the part of our readers as they rarely have the opportunity of reading so comprehensive a review of the subject treated as the JOURNAL presents this month.

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### Our Pittsburg Letter

IT has been the custom for the past few years for the Academy of Medicine and the County Medical Society to have an annual summer outing, which has usually taken the shape of boat excursions. This summer the Academy's outing consisted of a boat excursion down the Ohio River, while that of the County Society's consisted of a similar excursion up the Monongahela. Both were exceedingly enjoyable. Although it is midsummer, there are not a great many physicians out of town. But it is difficult to know the number of absentees, for a number of physicians take their summer vacations in fragments, *i. e.*, two or three weeks may be spent away from home during the summer in as many different periods.

The result of the examination by the State Board of Medical Examiners, held at Harrisburg in June, became known last month. Of 379 candidates possessing diplomas from regular medical schools, 41 failed to obtain the coveted license, while of 64 candidates examined by the Homeopathic Board eight were similarly unfortunate. The list of questions asked by the Board representing the Pennsylvania State Medical Society has again been published, and shows great care in their preparation. The Board is doing excellent work, which cannot fail to show in time in a greatly increased intelligence and education on the part of the average Pennsylvania physician. The work of the Board has the practically unanimous support of the profession.

The Board will require of those students who enter upon the study of medicine this fall evidence of the possession of a certain minimum education. Those who do not possess either a college or high school, academy or normal school diploma or teachers' certificate, will be compelled to pass an examination before one of the superintendents of the public schools in the elementary branches of an English common school education. This examination will be made more comprehensive during each of the next two succeeding years, when it will equal that required for entrance to the average college.

When we consider that only a few years ago students were admitted into the medical schools of this state without question as to their fitness to enter

upon the study of medicine, many of them being unable to read, write or even spell English correctly; and that the majority of students pursued their studies only two years (none more than three years), the contrast as compared with the state of affairs today is almost startling, and gratifying in the extreme to every friend of higher medical education.

Today the fitness of every candidate to begin the study of medicine is questioned. Every medical school in the state requires (or is about to require) four years' study.

The new wing of St. Francis Hospital is fast approaching completion. A new modern operating room is being built on the fourth floor.

Recently the Mayor, in accordance with a resolution of Councils, appointed a committee to investigate the city's water supply and to report specially upon the feasibility and practicability of filtration. None of those physicians or chemists who did such unselfish work on this question a couple of years ago as members of the joint water commission were appointed upon this new committee. The arguments made by this "joint committee" for sand filtration were so conclusive that it is difficult to see how this new committee can offer any other feasible scheme for pure city water.

Dr. J. Hartley Anderson, of this city, recently proposed, in a carefully prepared paper (*Pittsburgh Medical Review*), the inhalation of oxygen as a treatment for Bright's disease.

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### Medical Education in Chicago

There are nine "regular" schools in Chicago, to-wit: (1) Rush Medical College; (2) Chicago Medical College (Medical School of the Northwestern University); (3) College of Physicians and Surgeons; (4) Harvey Medical College; (5) Illinois Medical College (Chicago Summer School of Medicine); (6) Harvard Medical College (recently sued to compel a change of name, which conflicts with the Bostonese idea of the rights of her Harvard); (7) Woman's Medical College, and two Clinical Schools—the Polyclinic and the Post-Graduate. Then there are six "Homeopathic" Colleges, namely: (1) The Chicago Homeopathic; (2) The Hahnemann Medical College; (3) The National Medical College; (4) Dunham Medical College; (5) German Homeopathic Medical College; (6) Hering College of Homeopathy. Next may be mentioned the "Eclectic" School, Bennett Medical College; and, last of all, the "Physio-medical College." Total, 17! And this does not include a number not yet quite organized.—*American Journal of Surgery and Gynecology*.

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Dr. Coates: Well, Mr. Jones, how do you feel this morning?

Mr. Jones: Very well, Doctor, thanks to you and God!



### Union Medical Association of Northeastern Ohio

The ninety-ninth quarterly session of the Union Medical Association of Northeastern Ohio was held in the council chamber at Akron, August 11, about 25 members being present. A good program divided among eleven members had been prepared, but only two of the gentlemen on the program attended the meeting. The secretary and treasurer were the only officers in attendance. The extreme heat was the cause of the deficiencies in attendance and program.

The meeting was called to order at 10:50 A. M. by the secretary, Dr. T. W. Jackson, of Akron, and on motion, Dr. X. C. Scott was elected temporary chairman. The minutes of the last meeting were read and approved. The corresponding secretary's report in regard to the coming union meeting of the district medical societies of northern Ohio was read. The meeting will be held in Alliance, Grand Army Hall, on the third Tuesday in September. The Eastern Ohio Medical Association, the Union Medical Association of Columbiana, Stark and Mahoning Counties, and the Union Medical Association of Northeastern Ohio will take part in the meeting.

DR. X. C. SCOTT called attention to the fact that the Mississippi Valley Medical Association meets at St. Paul, September 15, and would conflict with the date of the union meeting, which was undesirable, as at least 25 physicians from this territory were going to the St. Paul meeting. On motion the secretary was instructed to have the date changed to the first Tuesday in October, if possible.

Canton was decided upon for the next regular meeting on the second Tuesday in November.

DR. ADAM SISLER of Manchester reported a case of injury to the skull by the explosion of a gun-breech. The accident happened last summer. A portion of the breech was driven into the right frontal region, making a wound in the skull  $1\frac{1}{2}$  by  $\frac{3}{4}$  inches in size, and upon removal of the steel and 11 or 12 spiculae of bone, two or three ounces of brain substance, badly bruised, escaped. The wound was carefully dressed and drainage provided for. The pulse was kept down to 40 by veratrum vivide to prevent inflammation. The wound gradually healed with no untoward symptoms. The soft parts were continually pulled together by adhesive plaster.

DR. W. W. LEONARD inquired if there were any oozing from the wound now, and Dr. Sisler replied that there was not.

DR. C. E. NORRIS of Akron then delivered the lecture, taking for his subject "Some General Considerations of Fever." He reviewed the medical history of fever and gave an account of the heat regulating apparatus of the body. He noted that heat production is greater in the fevered animal than in a normal animal under the same conditions, but less than in the animal under full diet and exercise. Also the febrile animal loses heat faster than the starving animal, but not so fast as the animal under full diet and exercise. The rest of his discourse Dr. Norris illustrated by the supply of fuel which is placed each fall into the coal bins of a house. Urea and fecal matter were the ashes of the body, the food being the fuel. It has been shown that neither urea nor loss of weight measure heat production, while the amount of carbon dioxid thrown off by the body is more nearly representative of it. Heat dissipation is increased in fever, but is less than the increase in heat production.

Both production and dissipation of heat in fever vary as the stage of the fever. Heat production occurs mostly in the muscle tissues.

At the conclusion of the lecture the Society adjourned for dinner, to re-assemble at 1 P. M.

In the afternoon Dr. T. H. Brannan of Canal Dover read an interesting report of cases, which will be published in full in the JOURNAL. The cases were discussed by Dr. N. S. Everhard of Wadsworth.

The corresponding secretary was instructed to notify members in arrears of the amount due from them. The secretary was instructed to send out notices of the union meeting at Alliance two weeks in advance. Dr. N. S. Everhard having resigned from the program of the union meeting, Dr. A. B. Walker of Canton was appointed to take his place.

Dr. J. G. GRANT of Akron was elected a member of the Association.

The program for the November meeting was announced as follows: Essays, Drs. George S. Peck of Youngstown, and W. W. Leonard of Akron; lecture, Dr. D. S. Bowman of Akron; reports of cases, Drs. H. Blankenhorn of Orrville, M. M. Bauer of Lake, J. F. Hobson of Cleveland, E. O. Leberman of Akron, P. Maxwell Foshay of Cleveland, N. S. Everhard of Wadsworth, H. A. Zimmerman of Youngstown; discussions: Drs. C. B. Parker of Cleveland, and J. F. Fraunfelter of Canton. Adjourned.

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## Book-Reviews

### Koenig on Tuberculosis of the Knee-joint

In a monograph (*Die Specielle Tuberculose der Knochen und Gelenke, I Das Kniegelenk*, pp. 186, Berlin, 1896, Verlag von Aug. Hirschwald), Koenig, who is perhaps the greatest authority on this subject, has given us his experience in 720 cases of tuberculosis of the knee-joint, treated in the Göttingen Clinic during a period of 18 years. The first portion of the work (70 pages) largely consists of statistical material, carefully compiled by Drs. F. Mertens and W. Koenig. Only the cases treated in hospitals are included, dispensary cases being omitted. 51.7 percent of the cases occurred in males, 292 cases occurred in the first decade of life; 348 cases were complicated by suppuration or the formation of *fistulae*; 341 were unaccompanied by suppuration. Attention is, however, called to the fact that in some of these cases the suppuration was due to tapping or incision, and that in some suppuration would probably have followed had they not been treated, so that these figures do not accurately represent the proportion of suppurative to non-suppurative cases. Of the cases complicated by pus formation, about one-half died; of the non-suppurative cases one-fourth died, thus showing the greater gravity of the former class, as would be expected.

The primary seat of the disease is difficult to locate prior to operation, indeed often it is impossible. It was found in 547 operative cases that 51.4 percent were primarily osseous, and 48.6 percent were primarily synovial. 144 cases were conservatively treated. It is probable that of these there

were few or none that had marked osseous lesions, so that, including the 144 non-operative cases in the list of synovial tuberculosis, there would be 44.5 percent of osseous disease and 55.5 percent of synovial disease. If it is remembered that the cases treated in the dispensary which were not included in these figures, probably had synovial tuberculosis, the proportion of synovial to osseous lesions becomes still greater. The tibia was the most frequent seat of osseous lesions.

The pathology and clinical history of the disease are very fully given by Koenig, but it is impossible here to refer to them.

It is very difficult to give general rules for the prognosis of tuberculosis of the knee-joint. Of 615 cases which were traced 205 (33 1-3 percent) have died. 81.4 percent of these died of tuberculosis of various organs; 2½ percent of 703 cases died of other infectious processes, and of iodoform or carbolic acid poisoning. In 11.7 percent of the cases the results of the treatment were "ideal," *i. e.*, motion of the joint was preserved. If the disease has progressed to the stage of a tubercular hydrops, or if the exudate has become fibrinous and partially organized, or if *fistulae* are present, the best result that can be expected is an ankylosed joint, or at most one with very limited motion. That tubercular knee-joints may finally heal after many months or even years of conservative or expectant treatment, is no doubt true, yet it should be remembered that a great many patients die during this long term; that in other cases, even if recovery takes place, the joints are deformed and the limb is practically useless; furthermore, tubercular *foci* may remain and subsequently give rise to trouble.

Throughout the entire work Koenig's standpoint is rather against the modern "conservative treatment" of knee-joint tuberculosis, and his opinion is "that the operative removal of the local tuberculosis is the only approximately safe method, and, if one considers a large number of cases, is also the least dangerous mode of treatment."

In children conservative measures are more often resorted to, and the chances of good results are much better than in adults. Resection, of course, is to be avoided as much as possible, up to the age of 16 years, owing to the danger of shortening. In adults it is not desirable to temporize, owing to the loss of time involved in conservative and expectant treatment; furthermore, fewer patients die as a result of the operation than as a result of conservative measures and of waiting aimlessly for a spontaneous cure.

Some general rules for treatment are as follows: In children the cases are treated conservatively, *i. e.*, contractures are overcome by gradual extension, or if need be, by forcible extension; the joints are immobilized in plaster of Paris, at first with rest in bed, later, after the subjective symptoms have subsided, the children are allowed to walk about on crutches. Joints in the position of valgus are forcibly rectified in narcosis. During the treatment by extension, from one to three iodoform injections are made. If there are

*fistulae*, if suppuration has occurred, if the mechanism of the joint is much impaired, or if conservative treatment fails to benefit, arthrectomy is done, together with extirpation of diseased *foci*.

2. In adults the disease, if early, is treated conservatively as in children. If these measures do not soon show favorable progress, if the disease is very marked, or if *fistulae* and suppuration exist, resection is at once done. In the worst cases amputation is necessary, though this is exceptional and is only performed when there is very extensive disease, or when the patient's general condition is poor.

Injections into the joint are made with a trocar and canula, or with a large aspirating needle. The puncture is usually made on the outer side of the joint, a little above the upper border of the patella; the instrument is first carried between the integument and the capsule for short distance, and then the capsule is punctured so that the openings in the skin and deeper structures are not parallel; this prevents the escape of the injected fluid. After evacuation of the contents of the joint, which process may, if need be, be aided by injecting sterile water or a 2 percent carbolic acid solution and manipulating the part, about 8 grams of a 5 percent carbolic acid solution are thrown in; or a 20 percent iodoform-glycerin emulsion is made use of; about two grams of iodoform are injected. The joint is then lightly kneaded and if possible, flexed and extended. No toxic symptoms referable to the iodoform or glycerin have been observed. These injections are repeated three or four times at intervals of from two to three weeks; if benefit is to follow, it will be noticed after the first or second injection; long-continued use of iodoform in this way is not believed in by Koenig. When it is remembered that the fluid cannot always reach all the diseased parts, for there may be portions of the joint which are cut off by the inflammatory process, and it is impossible to locate these diseased *foci*, it can be understood why injection fails to cure at times.

Of 154 cases treated by extension, injection and immobilizing dressings the results were good in 70 cases; in 40 of these the joint was movable. A few cases were treated with Koch's tuberculin, but this treatment has been abandoned. Koenig has not made use of Bier's method of artificial hyperemia, as he prefers to wait until it can be shown that a large proportion of cases can be rapidly and certainly cured by this procedure.

In 55 cases atypical operations were done, *i. e.*, local tubercular *foci* were removed, para-articular abscesses drained, etc. The attempt was made not to open the joint in these cases; the diseased tissue is thoroughly removed, the incisions being carried beyond the borders of the tubercular masses, much as in the treatment of malignant tumors. About one-half of these cases were in children. In 73 percent of the cases in which the above treatment was carried out, recovery took place with a movable joint.

Arthrectomy is resorted to in children when conservative measures

fail; under like circumstances in adults resection is done. 150 arthrectomies were performed, 128 of them in children. Of 133 cases in which the outcome is known 20 percent died as the immediate result of the operation. Though in a very few cases a movable joint was obtained, the general functional results were not as good as after resection. 76 cases got well with ankylosis in the extended position; in 24 cases the limb was flexed or curved, in 9 markedly so. Shortening followed in 60 percent of 94 cases which were examined for it. Of the cases of arthrectomy, 2 percent remained unhealed and either died or were subjected to other modes of treatment. All things considered, it appears that the results of arthrectomy are not particularly brilliant; after extirpation of the whole or nearly the whole synovial membrane it is hard to see how much mobility of the joint can exist. Passive motion begun early and carried out with the operation of the child and his parents, may be of use in attaining this end, but it is very difficult to carry out thoroughly. Finally, in a certain proportion of cases the limb becomes flexed or curved or remains shorter than the sound one.

The general conclusion of Koenig is that arthrectomy is the only operation for a good many diseased joints in children. For the details of the technic we shall have to refer the reader to the original. Suffice it to say that stress is laid on the importance of rendering the limb bloodless, as otherwise it is impossible to distinguish diseased from normal tissues. Either two lateral longitudinal incisions or the transverse incision of Volkmann are made. After thorough removal of the capsule and synovial membrane, and, if need be, the cartilage and diseased bone, iodoform is freely applied, the wound is drained, sutured, and the limb is placed in a Volkmann's splint. Koenig prefers to have the joint ankylosed in the extended position of the limb after this operation.

Resection is resorted to in persons over 16 years of age. 1. In cases in which suppuration and *fistulae* exist. 2. In cases in which the disease has advanced from the stage of hydrops to fungus of the joint when conservative measures have proved useless. 3. Particularly in cases where contractures exist or posterior luxation of the tibia has occurred. 4. In cases of *hydrops articuli* with tubercular granulations on the capsule. 5. In all long standing cases in which the limb, notwithstanding immobilization is painful on walking; in these there is usually osseous disease or caries of the joint surfaces. The older the patient, the earlier is the resection done. After the operation the union between the bones is either fibrous, cartilaginous or bony; the firmer the union the better the result, particularly if at the former seat of the joint there is an angle of flexion of from 5 to 10 degrees.

Of 300 resections, 222 were followed by a good result. The prognosis becomes progressively worse with the advancing age of the patient. The transpatellar incision of Volkmann is preferred. The importance of rendering the limb bloodless is here also emphasized, as is also the necessity of a thor-

ough removal of all diseased tissues, be it in the bone or in the soft parts; for the removal of tubercular synovial membrane, etc., the sharp spoon is not so efficient as the scissors. The bones should be sawn in such a manner that when they come together there will be an angle of 5 to 10 degrees. Iodoform is rubbed into the surfaces. The limb is dressed before the constricting bandage is removed and is kept for twenty-four hours or more in a nearly vertical position on a Volkmann's splint; hemorrhage has not been observed. Koenig deprecates the use of pegs for holding the bones in apposition.

In from eight to twelve days the drainage tubes and most of the stitches are removed. Under a second dressing, which remains for two weeks, healing usually takes place.

Amputation is necessary in certain cases, as, for instance, in very extensive disease, with suppuration when visceral disease exists or when other means fail. Of 91 cases of amputation 72 recovered, though 16 of these died in a year following the operation. Eleven patients lived for from 11 to 18 years after amputation.

Koenig observed 86 cases in which tuberculosis of the knee-joint began before the end of the third year of life. Contrary to the usually accepted view, the number of cases of osseous disease at this early age was relatively great; in 42 cases the disease began in one or other of the bones; in 21 it was primarily synovial and in 23 it was undetermined. One of the peculiarities of tuberculosis of the knee in young children is the frequency with which the lower epiphysis of the femur is affected, without involvement of the knee-joint; *fistulae* form in the popliteal space; this is explained by the fact that the tubercular focus is separated from the anterior of the joint by a thick layer of cartilage. Furthermore, the posterior part of the capsule is attached near the end of the bone, and the insertion of the crucial ligaments to the intercondyloid notch causes the posterior part of the epiphysis to be really extracapsular. The principles of the treatment of these cases have been given above; resection is to be avoided, and as little as possible of the cartilage is to be removed in order to avoid shortening.

When the patella is the seat of the disease the chances for obtaining good results in the treatment are unfavorable; operative removal is to be attempted when the joint is apparently sound. If the joint is diseased in addition to the patella, it is well not to attempt to obtain a movable articulation. Arthrectomy in children, resection in adults, together with removal of the patella are the procedures to be adopted. If there is marked suppuration and extensive disease, amputation is more often necessary in older patients than when the patella is not involved.

C. A. HAMANN.

**THE AMERICAN ACADEMY OF RAILWAY SURGEONS. REPORT OF THE SECOND ANNUAL MEETING, HELD AT CHICAGO, ILL., SEPT. 25, 26 AND 27, 1895. EDITED BY R. HARVEY REED, M. D., COLUMBUS, OHIO. CHICAGO: AMERICAN MEDICAL ASSOCIATION PRESS. 1896.**

The second volume of this proceedings is larger and much more carefully edited than the preceding one. It is a very creditable volume, and the scientific tone of the papers published therein shows that the Academy is doing a high type of work. There are many illustrations, chiefly portraits of prominent railroad surgeons. The paper, type, presswork and binding are models for all societies that publish transactions to copy.

A paper by Dr. R. Harvey Reed is worthy of mention in that it calls attention to the looseness of the common professional use of the words contagion and infection, and also to the fact that the word infection as applied to wounds is inaccurate. At the suggestion of Dr. Reed a committee was appointed to confer with similar committees from the American Medical Association and the American Surgical Association with the purpose of coining a new word which shall be exact in its description of this condition and acceptable to the profession.

Dr. W. H. Buechner, formerly of this city, has a paper in this volume describing a new method of amputation at the knee-joint.

In discussing a paper upon car sanitation by Dr. William T. Dalby, assistant surgeon of Union Pacific Railway at Salt Lake City, in which the writer urged that the surgeons impress upon their companies the great necessity for improvements in car hygiene, Dr. W. J. Galbraith, of Omaha, chief surgeon to the Union Pacific Railway, gave utterance to some very remarkable sentiments. The following is a fair sample: "What business have we to make such recommendations? None whatever. That is not our province whatever. I have fought the automatic coupler, I have fought the tubercular cars and the accident cars from the time our organizations of railroad societies started, and I hope this is the last fight I will have to make." One cannot wonder how so enlightened a man ever rose to so high a pinnacle! It is pleasing, indeed, to find a medical man, occupying a position of great power for good, opposing sanitary progress and means for reducing the mortality among railway employees. Fortunately, the profession has very few such renegades within its ranks, and they, with all their bluster, cannot permanently alter the march of progress.

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**TENTH ANNUAL REPORT OF THE STATE BOARD OF HEALTH OF THE STATE OF OHIO, FOR THE YEAR ENDING OCTOBER 31, 1895. COLUMBUS, OHIO: THE WESTBOTE COMPANY, STATE PRINTERS. 1896.**

This report is well compiled and contains much interesting matter. The secretary's request that the legislature shall furnish adequate means for collecting the vital statistics of the state is certainly a reasonable one. It is a burning disgrace to the great state of Ohio that no one can tell the number of births and deaths occurring within its borders, or its comparative healthfulness.

This report contains much matter relative to the water supply and sew-

erage of Cleveland. The paper read by Dr. Probst, the secretary, before the public sanitation meeting of the Cleveland Medical Society is reprinted in full.

The reports upon the sanitary condition of the various cities and towns of the state are very interesting reading. It is surprising to find that many of the smaller cities have in active operation plants for the disposal of sewage and filtration of water. Some have even the dual sewerage system (Canton, for instance). All of which shows how backward is our own city in sanitary appliances.

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**THE MULTUM IN PARVO REFERENCE AND DOSE BOOK.** By C. Henri Leonard, M. A., M. D., Professor of the Medical and Surgical Diseases of Women, Detroit College of Medicine. Flexible leather, 143 pages, price 75 cents. Detroit, 1896: The Illustrated Medical Journal Co., Publishers.

This is a recent edition of the Dose Book, of which the title page informs us some forty thousand copies have been issued. The present edition is printed on very thin paper, and is bound in red leather, round corners, so as to make it specially light and handy for the pocket; the weight is not two and a half ounces. Besides the doses of some 3,500 preparations being given, it has numerous tables, such as the solubility of chemicals, pronounciation of medical proper names, poisons and their antidotes, incompatibles, tests for urinary deposits, abbreviations, tables of fees, etc. It will be found a handy pocket companion.

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**MORTALITY FROM CASUALTIES** BY ELIAS J. MARSH, M. D., MEDICAL DIRECTOR OF THE MUTUAL LIFE INSURANCE COMPANY. PUBLISHED BY THE COMPANY, NEW YORK, 1896.

This interesting monograph is a report by Dr. Marsh, Medical Director of the Mutual Life Insurance Company of New York to the President of the company, Mr. Richard A. McCurdy. This company is again to be commended for placing its statistics, which are of the highest value, at the disposal of the medical profession.

This consideration of the mortality experience of this company from casualty gives rise to many conclusions of interest. A period of ten years—1884 to 1893—is chosen for examination during which the company had 759 policy-holders die by accident, among 17,375 deaths from all causes. The tables show that railway employees of all kinds are extremely hazardous risks. Not a single death occurred in the period chosen of a passenger traveling in an ocean steamer, although former reports had a decided proportion of such. This clearly shows the improvement in the safety of this kind of travel. No less than 84 deaths in 759 were due to injuries received from horses or wagons, two of those killed being physicians. It is found that the deaths by homicide were in nearly all cases of men whose policies had run but a short time. Only three deaths occurred by homicide north of Virginia and east of Ohio. The proportion of homicides has increased from five per cent in 1873 to ten per cent in 1893. Deaths from firearms



are much too frequent—due to the universal using of firearms in this country. Deaths from heat were chiefly in the middle tier of States. Workers about machinery are clearly shown to be bad risks. Only one death in 759 was due to bicycle accident although the report covers the high-wheel period. However in that period the bicycle was not in such universal use.

In summing up it is noted that the total mortality from accident has declined nearly one-third since the report of 1873. This is largely due to the fact that the policy-holders of the company averaged a much higher age in this last report, and of course with that was increased mortality from natural causes. Allowing for this indeed, the proportion of deaths from accident is seen to be very nearly a constant factor.

The interest in these statistical reports is so great that it is to be hoped that the company will continue the policy of publishing them.

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**DIET FOR THE SICK.** Contributed by Miss E. Hibbard, Principal of Nurses' Training School, Grace Hospital, Detroit, and Mrs. Emma Drant, Matron of Michigan College of Medicine Hospital, Detroit. Second edition. Enlarged. Limp Cloth, 17 mo., 100 pages. Price 25 cents. Postpaid. Detroit, Mich: The Illustrated Medical Journal Co. 1896.

In this little book there is, besides the useful formulae for "Sick Dishes," foods and cooling drinks for convalescents, quite complete Diet Tables for use in anemia, Bright's disease, calculus, cancer, chlorosis, cholera infantum, constipation, consumption, diabetes, diarrhea, dyspepsia, fevers, gout, nervous affections, obesity, phthisis, rheumatism, uterine fibroids. It also gives various nutritive enemas. The physician can use it to advantage in explaining his orders for suitable dishes for his patient, leaving the book with the nurse.

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### Additional Notes

#### On Dr. Garrison's Case of Ectopic Pregnancy in a Cow

The following additional data in regard to this case, a report of which will be found on page 420 of this number of the JOURNAL, have been received from Dr. Garrison too late for insertion with the main report.

The Fallopian tubes were intact—there was no place where a tubal pregnancy might have ruptured.

There were no adhesions between the sac and the abdominal parietes on the site of the incision for necropsy, but there probably were on the other portions of the sac. The rupture of some of these adhesions accounted for the bloody fluid in the peritoneal cavity.

The sac was nourished by a nutrient artery from the mesentery.

When Dr. Garrison first saw the heifer her belly was retracted and remained so until 30 minutes before she was killed when it sagged down. During these last 30 minutes the cow was in a state of collapse, the pulse after having been 70 or 80, which is double the normal frequency, became imperceptible, the extremities were cold, and sweating occurred.

## A Survival of Savage Credulity

Dr. Dan Milliken of Hamilton, Ohio, is evidently a man of comprehensive knowledge, close reasoning, rare humor, and remarkable power of expression. This we infer from a perusal of his presidential address, entitled *A Study in Credulity*, delivered before the Ohio State Medical Society at its last annual meeting. He opened with a reference to the universal tendency of savages—a tendency shared by children and degenerate—to superstition, and particularly to the superstition of regarding disease as an evil spirit, something to be enticed or driven out of the body; and he proceeded to show that a conviction akin to that superstition had dominated the humoral pathology, still survived among the laity, and even now was not altogether conquered by physicians, so that it took a man of strong mind to stand out and not finally be influenced by the notion of the people among whom he was at work. This thought, he says, often comes to him when he hears a patient speak of his disease as “it.” “We often hear,” he adds, “that ‘it’ *struck in*, with the most serious results. I have been called out of bed to see a patient who was awakened with a numbness of the toe, and straightway sent for his brother, his doctor and his priest, lest ‘it’ should creep up to some vital organ and send him to the realm of shades in shameful informality. And very recently I saw a poor creature with a slowly failing heart and swelling legs who with the tincture of iodine had painted a garter about her leg in the vague hope that this might prevent ‘it’ from crawling up to drown her.”

It was on some such notion, he thinks, that the old practice of bleeding, salivating, and giving repeated purges and emetics was founded. Up to very recent years, he says, intolerable drugs were put into the body “with a more or less definite idea of making it untenable to any other spirit than the owner, and the practice was carried so far that it was oftentimes a very nice question whether the landlord of this house of clay—the Ego himself had not better move out and find quieter quarters. The notion of exorcising disease, Dr. Milliken imagines, has infected the surgeon, who “carries his voodoo in a dredging-box and calls it iodoform.” “He doesn’t precisely say that it is a lucky thing to use, though that is in his heart of hearts.” “Press your surgeon hard enough and he will tell you that iodoforms slowly gives off iodine in the wound or on its edges, but he will not tell you why it is better than other substances which do the like, nor will he impart to you a reason why he does not use iodine itself in known quantity.”

After picturing the humoral pathology as “only a higher form of personification of the morbid principle,” which “substituted a vague and shadowy entity for the half corporeal demon which had haunted pathology for so many centuries,” Dr. Milliken says: “We do much better now. We have

a pathology of the zymotic diseases which is harmonious and strictly scientific and conformable to the true spirit of induction. But it falls in my way to say, today, that it is not at all to the credit of our craft that the old credulity breaks out anew with every announcement of progress in bacteriology; greedy, gulping acceptance of principles, unproved and half proved, in bacteriology is the disgrace of the day; most of us have been obliged to change front three times on the bacteriology of diphtheria, and it is certain as death and taxes that we shall play the jumping-jack through future years if we do not, after the manner of scientific men, receive valuable hypothesis as hypothesis."

Proprietary preparations, Dr. Milliken declares, "do not differ in any regard from the patent medicines which are swallowed in such quantities by the laity to feed the inextinguishable laughter of the doctors." "It is not in order," he adds, "for you or me to sneer at the girl who buys love-powders in the kitchen or madam who buys subscription books in the parlor, if we, snickering in the office, are seduced by the drummer's smooth tongue into the purchase and use of secret remedies. . . . I am told that the formula is on each bottle. The formula, indeed! The Egyptian sphinx has a very open countenance, yet the ages have not wrested her secret from her . . . The formula on each bottle! Spare us such formulas in the kitchen, for if the cook has only the names of her ingredients hinted to her, 'combined with aromatics,' she will never be able to concretely realize the theoretic difference between pudding and bread or between plain omelet and baked custard, and the only certainties she will deal out to us will be dyspepsia and consuming wrath. . . . There are superstitions in medicines to be sloughed; there are noble certainties to be attained. Throw away your samples and practice medicine!"

But it is not Dr. Milliken's opinion that, judged as a whole, the medical profession is credulous; its genius he does not doubt, will meet and neutralize the evil tendency to credulity, for "it has ever been the proud boast of the doctor that he has dissipated doubt and superstition, has gone far beyond the bounds of his art to bring certainty and scientific apprehension to the world."—Editorial in *New York Medical Journal*.

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**Dr. Geo. N. Stewart** will deliver the address at the opening exercises of the Medical Department of Western Reserve University, September 23.

**The papers** of August 14 announced that Dr. Edward Meggenhoffen, of Chillicothe, was headed for this city with another man's wife in tow. It is to be regretted that there was not time to inform the doctor that there are no vacancies in this city.

## Medical News

**Dr. J. A. Riley** was ill for two weeks early in August.

**Dr. Henry S. Upson** returned from his vacation August 29.

**Dr. Dudley P. Allen** left the latter part of July for a short trip to Europe.

**Dr. W. H. Buechner** is very ill at the home of his father in Youngstown.

**Dr. J. E. Cook** spent a short vacation in the East about the middle of August.

**Dr. Herbert L. Frost**, of this city, was married, August 3, to Miss Fannie Smith Lines.

**Dr. William Thomas Corlett** was recently appointed dermatologist to Lakeside Hospital.

**The British Medical Association** has just voted to meet in Montreal, Canada, next year.

**Dr. B. W. Holliday** of this city dislocated his shoulder by a fall from his bicycle on August 17.

**Dr. D. L. Moore**, of Columbus, was the guest of Dr. George W. Crile for a few days recently.

**Drs. J. B. McGee and J. H. Belts** spent some time at Muskoka Lake the early part of August.

**Dr. O. T. Thomas** spent the first ten days of August visiting at his old home in Wilkes-Barre, Pa.

**Dr. H. C. Brainerd's** daughter Edith was married August 20 to Rev. E. E. Wilson of New Waterford.

**Announcement** is made of the engagement of Dr. E. G. Carpenter to Miss McCormick, of Mt. Vernon.

**Dr. and Mrs. N. S. Everhard**, of Wadsworth, were visitors in the city during the first week of the Centennial.

**A severe** local epidemic of diphtheria was reported early in August as raging in Williamsport, Pickaway County.

**Dr. Williard C. Rank** of Newark, O., has been appointed assistant surgeon to the Seventeenth Regiment, O. N. G.

**Dr. C. J. Aldrich** has removed to the Corning house on the southwest corner of Prospect street and Sterling avenue.

**Dr. Thos. Chas. Martin** has resigned from the Professorship of Rectal and Genitourinary Surgery in the Cleveland Medical College.

**The Hygeia Sanitarium** at 900 Fairmount Street has been closed and the proprietor, Dr. W. S. Bookwalter, has gone to Ashtabula.

**Dr. H. Edwards**, a dentist of Findlay, lost both eyes and received a number of severe scalds by the explosion of a vulcanizing apparatus.

**Dr. J. F. Armstrong** suffered the loss of his oldest son, Kirtland R., from tuberculosis, August 13. He has the sympathy of the profession.

**Professor Klebs**, the German bacteriologist, has gone to Chicago as professor in Rush Medical College, and also in the Chicago Post-Graduate Medical School.

**Out of eight** candidates for license to practice medicine in this state who were recently examined by the State Board of Registration and Examination, six were found qualified.

**Dr. J. A. Burgoyne** was appointed physician to the Institute for the Deaf and Dumb at Columbus August 14, to succeed Dr. Lippett, who has recently resigned after four years' service.

**Dr. M. G. Moore**, of 614 Ontario Street, died August 24 at Mantua from apoplexy. He was a graduate of the Medical Department of Western Reserve University in the class of 1870.

**The "World's Congress of Medico-Climatology"** is being used by its corresponding secretary, Dr. W. S. Rowley, to put upon the professional market a certain southern mineral water.

**Dr. S. D. Brooks**, surgeon to the Marine Hospital station at St. Louis, and formerly occupying the same position in this city, has been visiting his many friends here lately with Mrs. Brooks.

**Dr. J. J. Erwin**, treasurer of the National Association of Military Surgeons, reports that preparations for the meeting of the Association in Columbus in May, 1897, are progressing actively and favorably.

**The John Hancock Mutual Life Insurance Company** on July 15 last reduced their medical examiners' fees upon policies of \$1,000 or less to \$3.00. On July 22 the fees were put back to the old figure, \$5.00.

**Dr. J. J. Erwin**, formerly assistant surgeon to the 5th Regiment of Infantry, O. N. G., was recently transferred to the 1st Artillery. On August 20 he joined several batteries in Akron in their march to camp in this city.

**The American Public Health Association** will hold its twenty-fourth annual meeting in Buffalo, September 15 to 18. In connection with the meeting there will be a large exhibition of sanitary appliances of all kinds.

**Dr. J. S. Crawford**, of Omaha, formerly of Cleveland, was killed, August 7, while crossing the tracks of the Missouri Pacific Railroad in Omaha. His remains were brought to this city by his wife for interment in Riverside Cemetery.

**The** Equitable Life Insurance Company has heeded the protests of its examiners and announced that hereafter the fee for medical examinations will be \$5.00, as formerly. The reduction to \$3.00 has, as readily predicted, proved to be a very poor economy.

**Dr. Albert N. Read**, of Norwalk, a graduate of Jefferson Medical College, Philadelphia, in the year 1846, died August 25 at the advanced age of 81 years. During the war he was chief sanitary inspector of the Cumberland division. He was at all times a prominent citizen.

**The Voice and Cleveland** is the name of the paper lately formed from the remains of the old *Sun and Voice* by infusing the activity of the *Cleveland*. Mr. W. E. Sage is the editor of the new enterprise, which has our best wishes for prosperity. The early numbers bespeak an active, fearless and bright journal.

**On August 17** the steward at the Cleveland State Hospital for the Insane, Mr. A. M. Parrish, received from Governor Bushnell a request for his resignation, which was promptly tendered. His successor has just resigned a seat in the Legislature in anticipation of the happy event of his becoming steward to the Asylum.

**Dr. Fred. C. Taylor**, of this city, has been very ill with acute articular rheumatism. In addition to this misfortune and the death of his father last spring, his oldest brother died of typhoid fever early in August. Dr. Taylor deserves the sympathy of his many friends in his excess of misfortune, and that he has it needs not to be stated here.

**The** American Association of Obstetricians and Gynecologists will meet at Richmond, Va., September 22, 23 and 24. A good program has been prepared with the following Ohio physicians down for papers: Dr. Rufus B. Hall, Cincinnati; Dr. J. F. Baldwin, Columbus; Dr. T. Tod Gilliam, Columbus; Dr. C. A. L. Reed of Cincinnati; and Dr. George S. Peck of Youngstown.

**A vigorous** attempt was made by some members of the Tippecanoe (Republican) Club, at a special meeting early in August, to reconsider the resolutions passed at an earlier meeting asking the Governor to remove Dr. Eyman from his post as superintendent of the Cleveland State Hospital for the Insane and appoint a Republican in his stead. The effort was unsuccessful, however.

**The** Third Annual Meeting of the American Academy of Railway Surgeons will occur at Chicago, September 23, 24 and 25. The following Ohio physicians are down for papers: Dr. August Rhu, Marion; Dr. R. Harvey Reed, Columbus; Dr. James E. Pilcher, Columbus; Dr. George W. Crile, Cleveland; Dr. Webb J. Kelly, Galion; Dr. W. L. Buechner, Youngstown; Dr. W. A. Ward, Conneaut; Dr. W. H. Buechner, Cleveland; and Dr. R. D. Mussey, Cincinnati.

**The attorney** of the Hygeia Medical College of Cincinnati has been granted time by the State Board of Medical Registration and Examination in which to make his plea in behalf of the institution. As the *Lancet-Clinic* remarks, it is hard to see any reason for delay in the case of a college, no member of whose faculty at any time has been a qualified physician, but at the same time the profession must trust to the judgment of the Board in these early days of the enforcement of the law.

**The last** certificates to graduates in medicine issued by the State Board were forwarded August 13. Therefore, all physicians in the State entitled to certificates upon the basis of holding diplomas from medical schools, are now in possession of them, with the exception of those applying on the basis of foreign and Canadian schools. The latter will be acted upon at the October meeting of the Board. The ten-year legal practitioners are still to be acted upon and present many difficult problems to the Board.

**The smoke** ordinance finally passed the city council, August 3. Dr. J. L. Hess, the health officer, at once served notice upon the heads of the various departments of the city government that they had 30 days in which to abate the smoke nuisance in the city's institutions. So soon as the city is observing the law Dr. Hess will turn his attention to the private producers of smoke. As there are now several efficient smoke-consuming devices, it is to be hoped that the law will be well enforced. Under present conditions it is hardly possible for it to be a hardship to anyone, as the consumers all show a saving in fuel.

**The Cleveland Journal of Medicine** announces its removal to new and commodious quarters in the New England Building, a sky-scraper on Euclid Avenue. The JOURNAL has demonstrated the fact that a publication may achieve greatness, even though domiciled in unpretentious quarters. We congratulate the JOURNAL on its prosperity; we shall expect its good qualities to be emphasized, now that it is in a location so eminently favorable to medical journalism.—*The Medical Fortnightly*.

**Dr. Joseph F. Chau**, of Cleveland, O., has applied to the State Board of Examiners of that state for registration. Dr. Chau is said to be a graduate of the Hong Wo College, of O'Moon, China.—*Atlantic Medical Weekly*.

**According** to statistics there are 7,579 physicians in the state of Ohio, of which 4,030 belong to the regular school, 1,199 are eclectics, 678 homeopaths, 155 physio-medics, and 757 unclassified. It is estimated that the new law regulating the practice of medicine has driven out between 1,500 and 2,000 practitioners from the state of Ohio, and it is quite likely that others will find the climate entirely too warm for comfort.—*Columbus Medical Journal*.

**Dr. H. M. W. Moore**, of Columbus, Assistant Surgeon General of the state, spent a portion of each week in the city during the Centennial, attending to his duties at Camp Moses Cleaveland.

**The Cleveland Journal of Medicine** has been so prosperous in its short life that it has outgrown its old quarters, and has moved to new offices in the New England Building.

It is deserving of this success, for it is excellently edited and will compare favorably with the best of medical journals in the quality and quantity of its contents. It is progressive and fairminded, and what I like about it most of all is the attention which it gives to the experiences and investigations of local physicians. Cleveland has many brilliant men in the ranks of doctors, and their contributions are as able as any published.—*The Voice and Cleveland*.

**Dr. Clarence O. Arey** died, August 11, at his residence, 985 E. Madison Avenue, this city. Dr. Arey was a prominent young architect of this city a few years ago, but about 1890 he became interested in medicine, partly because of ill-health and partly because of the death of one of his children. He commenced his studies in the Medical Department of Western Reserve University in the autumn of 1891, and spent two years in that school. In September, 1893, he entered the third year course of the Medical Department of the University of Pennsylvania, and graduated there in the class of 1894.

During his whole period of study and subsequently, Dr. Arey's greatest interest centered in the clinical uses of the microscope, more especially bacteriology, in which he was an enthusiast. So little did he care for the practice of medicine that a few months previous to his untimely death he announced his return to the practice of his original profession.

**The following** is clipped from one of our local daily papers and is of great interest to the medical profession. It may be merely an attempt to "bluff" the State Board, or it may mean that the law will be tested.

"Attorney B. B. Avery is in Cincinnati securing evidence to be introduced in an action soon to be brought for the purpose of testing the constitutionality of the recently enacted law regulating the practice of medicine in the state of Ohio.

"The State Board has rejected diplomas issued by certain colleges in the state, refusing recognition to such graduates, and it is in the interests of these physicians that Mr. Avery is taking steps to test the validity of the law."

**Whereas, Dr. I. N. Love** has found it incumbent on him to sever his connection with the Marion-Sims College of Medicine, the members of the faculty of that institution embrace this occasion to express their appreciation of his past services, and to extend to him their hope that in all his future connections he will find both pleasure and profit.

B. M. HYPES,  
R. C. ATKINSON,  
C. BARCK,

*Committee.*



**The Ohio State Board** of Medical Registration and Examination will hold its next regular meeting at its quarters in the Y. M. C. A. building August 10. The Board has just completed a fireproof vault. The files are classified under two general divisions—Physicians and Surgeons and Medical Colleges—and are so arranged that the papers relative to any medical college can be produced in a moment. The same may be said in reference to the papers of any physician who has registered in the state. The methodical manner in which the Board conducts its business is highly commendatory, and is sufficient to convince anyone that they mean business and have come to stay.—*Columbus Medical Journal*.

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**KENTUCKY SCHOOL OF MEDICINE**.—At a recent meeting of the faculty of this school the following appointments were made: Dr. Louis Frank, lecturer on clinical and operative gynecology; Dr. Henry E. Tuley, lecturer on obstetrics; Dr. Carl Weidner, lecturer on physiology; Dr. W. E. Grant, lecturer on anatomy; Dr. Ewing Marshall, lecturer on physical diagnosis; Dr. T. C. Evans, lecturer on ophthalmology, otology and laryngology.

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**SELF-RESPECT MORE VALUABLE THAN POSITION**. — Dr. James G. Kiernan, of Chicago, informs us that after an editorial service of nearly ten years upon the *Medical Standard*, he has now severed his connection with that journal, because of the insistence, "by the publishers, upon intruding nostrum advertisements and the conversion of the journal into a 'write up' organ for nostrums and allied performances."—*Medical News*.

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**OHIO MIDWIVES**.—"The Ohio Medical University has a department of midwifery, the curriculum of which extends over a period of two years, and includes instruction in anatomy, physiology, chemistry, materia medica, embryology, obstetrics, diseases of pregnancy, diseases of infancy, therapeutics, bacteriology, and clinical obstetrics. This is a move which the city of New York might do well to take cognizance of, with a view to the inauguration of a system of obligatory instruction for its large number of uneducated and ill-trained midwives."—*American Medico-Surgical Bulletin*.

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**BUREAU OF THE MEDICAL PRESS**.—It has long been a subject of comment that the medical journals were slow to appreciate the advantages and benefits to be derived from a representation at the National and State Medical Society meetings, and, indeed, exhibiting an indifference in reporting the proceedings. The fact that hardly a half-dozen journals were seen at the recent meeting of the American Medical Association meeting surely reflects no credit upon the enterprise of our medical publishers. It seems, however,

to have an explanation in the matter of expense. Unless the publisher or editor has the leisure time to attend the meeting himself, it is difficult to secure a representative who will do justice to the publication, to say nothing of the expense of sending him and maintaining quarters during the meeting. Still there is no question that the society meeting affords the very best opportunity for a journal to get in touch with both the profession and the advertiser, and if closely and systematically followed, will ultimately insure a degree of success unattainable in any other way. We are pleased to announce that a new plan will shortly be inaugurated whereby the leading journals from all parts of the country may be represented at our principal society meetings, at a nominal expense. Mr. Chas. Wood Fassett, at the solicitation of a number of publishers, will, at the meeting of the Mississippi Valley Medical Association, open a Bureau of Information and Publicity for the Medical Press, and from his long experience in journalistic work, we predict that it will be an unqualified success. A catalog will be issued for the occasion, showing the medical periodicals and reference books contained in the Bureau, and advertising matter of various kinds will be distributed for members. Those wishing membership, should apply at once for blanks and full information to Chas. Wood Fassett, Secretary, Mackinac Island, Mich., (care Grand Hotel), until September 1; after that date, St. Louis, Mo. The date of this meeting, at St. Paul, has been changed to September 15, with an excursion to Yellowstone National Park on the 18th.

This JOURNAL will be on file at the Bureau, and our readers and friends in attendance at this meeting are cordially invited to make the Bureau headquarters. They will find plenty of good reading matter, medical dictionaries, and the latest reference books, as well as writing materials and desks for use of visitors.

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**CHANGES IN THE FACULTY.**—At a meeting of the faculty of the Kentucky School of Medicine of Louisville, Ky., held on the 21st day of July, by a vote of five to one the chairs occupied by Dr. W. H. Wathen and Dr. M. F. Coomies were declared vacant. It has been an open secret among the profession for a number of years that there has been friction among the faculty of this school, and some credence was given this when about a year ago it became known that Dr. Wathen had been deposed from the position of dean of the faculty, which he had occupied for a number of years, and that Dr. S. E. Woody had been elected in his place.—*Medical News*.

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### The Journal

At St. Paul go into the reading room provided by the medical journals and read the JOURNAL. All our friends will be made welcome there

## Surgeons at Camp Moses Cleaveland

The following physicians from various parts of the state have been in Cleveland during the Centennial period in pursuance of their duties as surgeons to the O. N. G.: With the First Brigade—1st and 16th regiments of infantry and Troop A, First Cavalry—were Assistant surgeons H. Castle and G. I. Cullen of Cincinnati, Surgeon A. L. Osborne (Brigade surgeon) of Norwalk, Assistant Surgeon P. L. Myers of Fostoria, Assistant Surgeon J. D. Howe of Toledo, and Assistant Surgeon F. E. Bunts of Cleveland. With the Second Brigade—8th and 17th infantry—were Surgeon E. C. Farquhar of Zanesville, Assistant Surgeon G. H. Wuchter of Wadsworth, Assistant Surgeon Arthur M. Dent of Coshocton, and Assistant Surgeon D. A. Rennels of McArthur. With the Third Brigade—2d and 14th infantry—were Surgeon F. D. Bain of Kenton, Assistant Surgeon D. W. Steiner of Lima, Assistant Surgeon Z. T. Houseman of Bairdstown, Assistant Surgeon Otto C. Stutz of Upper Sandusky, and Surgeon L. T. Guerin (Brigade surgeon) of Columbus, Assistant Surgeon Fred. Gunsaulus of Columbus, Assistant Surgeon E. M. Semans of Columbus, and Assistant Surgeon T. B. Wright of Circleville. With the Fourth Brigade—3d and 5th infantry—which was in camp August 10 to 16, Surgeon J. A. Sterret of Troy, Assistant Surgeons T. H. Holmes of Hillsboro, F. C. Weaver, Dayton, and H. M. Pearce, Urbana; Surgeon G. C. Ashmun, Cleveland, and Assistant Surgeon M. H. McIlrath.

The medical staff of the artillery brigade—the last to occupy the camp was as follows: Surgeon Major H. M. W. Moose of Columbus, Assistant Surgeon General; Assistant Surgeon Capt. J. J. Erwin of Cleveland; Assistant Surgeon, Capt. W. A. Westervelt of Columbus. The hospital equipment of this brigade was much the most extensive and complete of any occupying the camp by reason of the extra hazard which attends handling the guns and horses of the artillery.

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## The March of Progress

**SIMPLER SPELLING.**—In this journal we wish to adopt the simplified method of spelling as rapidly as it is recognized by liberal scholars. To that end we avoid the use of diphthongs, excepting where they are of real use to indicate the Latin plural and genitive case. Thus, changing the *ae* and *oe* to the simple *e*, we say "anesthetic," "edema," "hemorrhage," and "diarrhea." We hope the time will soon come when it will be generally recognized that we can also drop the extra "rh" in such words as those quoted.

We also avoid the use of the double adjective termination "ic-al" by saying "chemic," "obstetric," "physiologic," "pathologic," "anatomic," etc. —*The Medical Council.*

## Condensed Table of Mortality in Cleveland for July, 1896

By courtesy of Dr. J. L. Hess, Health Officer

<b>I.—FEVERS.</b>			Jaundice.....		1
Influenza.....	0		Hepatitis.....	1	
Typhoid.....	13		Acute yellow atrophy.....	0	
Measles.....	4		Abscess of liver.....	0	
Diphtheria.....	2		Cirrhosis of liver.....	0	
Varicella.....	0				204
Intermittent fever.....	0		<b>V.—DISEASES OF CIRCULATORY SYSTEM.</b>		
Cerebro-spinal.....	0		Dilatation of heart.....	0	
Erysipelas.....	0		Fatty degeneration of heart.....	1	
	19		Rupture of heart.....	0	
<b>II.—DISEASES OF THE NERVOUS SYSTEM.</b>			Pericarditis.....	2	
Marasmus.....	25		Endocarditis.....	12	
Meningitis.....	23		Myocarditis.....	8	
Softening of brain.....	2		Valvular disease.....	1	
Abscess of brain.....	1		Aneurism.....	0	
Apoplexy.....	4		Anemia.....	1	
Epilepsy.....	0		Pyemia.....	0	
Tumor of brain.....	1		Septicemia.....	5	
Sclerosis of brain.....	0		Puerperal fever.....	2	
Aneurism of brain.....	0		Rheumatism.....	6	
Tetanus.....	1		Rickets.....	0	
Cerebral embolism.....	2		Syphilis.....	0	
Myelitis.....	1				38
Dentition.....	5		<b>VI.—URINARY DISEASES.</b>		
Convulsions.....	47		Nephritis.....	4	
	112		Acute Bright's disease.....	0	
<b>III.—DISEASES OF RESPIRATORY SYSTEM.</b>			Chronic Bright's disease.....	0	
Croup.....	1		Cystitis.....	1	
Croup—membranous.....	2		Diabetes.....	1	
Bronchitis.....	13				6
Phthisis.....	29		<b>VII.—GENERATIVE SYSTEM.</b>		
Pneumonia.....	41		Postpartum hemorrhage.....	0	
Pleurisy.....	0		Cancer of breast.....	0	
Congestion of the lungs.....	4		Cancer of uterus.....	1	
Edema of the lungs.....	0		Puerperal eclampsia.....	0	
Gangrene of the lungs.....	0				1
Tuberculosis.....	15		<b>VIII.—VIOLENT CAUSES.</b>		
Cancer.....	9		Accident.....	25	
Asthma.....	1		Suicide by hanging.....	0	
Whooping cough.....	9		Suicide by shooting.....	0	
	124		Suicide by Poisoning.....	1	
<b>IV.—DISEASES OF THE DIGESTIVE SYSTEM.</b>			Suicide by drowning.....	1	
Perforation of intestines.....	1		Homicide.....	1	
Strangulated hernia.....	1		Asphyxia by overlying.....	1	
Gallstone.....	1		Burns or scalds.....	2	
Gastritis.....	3		Railroad injuries.....	2	
Gastric ulcer.....	1		Shock.....	2	
Cancer of liver.....	2				35
Cancer of stomach.....	1		<b>IX.—UNCLASSIFIED.</b>		
Enteritis.....	16		Inanition.....	41	
Peritonitis.....	4		Premature birth.....	4	
Appendicitis.....	1		Senile debility.....	32	
Obstruction of intestines.....	3		Alcoholism.....	1	
Diarrhea.....	7				75
Cholera Infantum.....	123				
Enterocolitis.....	20				
Cholera morbus.....	3				

Total deaths for July, 617. Total deaths for July, 1895, 533.

Annual death-rate per 1000 during the month (estimated population 330,279) 22.007+

### Mississippi Valley Medical Association

My Dear Doctor:—I desire to announce to you that the date of the meeting of the Mississippi Valley Medical Association has been changed to September 15, 16, 17, 18, in order to permit the members and their families to take the opportunity accorded by this change to make a pleasant tour through the Yellowstone Park, so justly celebrated as the wonderland of America.

Prominent resident members of our Association in St. Paul and Minneapolis are formulating plans for the special Yellowstone Park excursion trip, to leave on the evening of September 18, arriving in Mammoth Hot Springs in the Yellowstone Park about noon on the following Sunday, and devoting the following five days to the wonders of this remarkable region, returning to St. Paul Sunday, September 27.

The cost of the trip, including all expenses, west of St. Paul, will be announced in due season, but we are authorized to say that the figure will be a very favorable one, and we simply wish at this time to make the preliminary announcement of this most enjoyable feature of the St. Paul meeting, so as to give members the opportunity of making their plans in advance to join the party. It is desirable that there be a party of 100 or more, in order to obtain the benefit of the special train service in both directions.

It is urged that all members who desire to join the party should send their names to Dr. C. A. Wheaton, chairman of the Committee of Arrangements, St. Paul, at as early a date as possible. If you desire to read a paper before the meeting, please send to me the title at once.

Very truly yours,

HANAU W. LOEB,  
*Secretary.*

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BUSINESS DEPARTMENT CLEVELAND JOURNAL OF MEDICINE

P. MAXWELL FOSHAY, M. D., BUSINESS MANAGER

SPECIAL REPRESENTATIVES IN THE EASTERN STATES, MONIHAN-FAIRCHILD SPECIAL AGENCY  
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## Clinical Observations on Cases of Simple Anemia or Chlorosis Occurring in Young Women in the Decade following Puberty

BY J. H. MONTGOMERY, M. D., ERIE, PA.

**I**N presenting to the Society the subject of anemia, I shall confine myself entirely to my own experience with cases of simple anemia, and at the same time advance some conclusions that I have drawn from my observations of this class of cases. To those interested in this subject I would refer to the very excellent articles in "Pepper's System," and in Keating's "Diseases of Children," as well as to Cohnheim's "Lectures on the Pathology of the Circulation." My inferences may be fallacious, yet I am so positive of the same being correct that I do not hesitate to give a prognosis and treat such cases on the results of these observations. To anticipate I may say that the results obtained may be classed with the most brilliant obtained from internal medication, and are equally gratifying to patient and physician.

In the present paper I restrict the term "anemia" to that class of cases commonly met with in young women, in the decade following puberty. The subjects of this disease frequently make the diagnosis of their trouble by saying, "I think my blood must be out of order." Briefly the symptoms of the disease may be described as follows: A young woman, aged from 14-25 years consults a physician for progressive loss of strength, and usually marked dyspnea on the slightest exertion, and, in addition, sometimes epigastric distress after the ingestion of food. Friends may have commented on the lack of color in the face. Often the patient complains of cardiac palpitation, and is alarmed about the probable existence of a cardiac lesion. In addition to these symptoms, there is usually a history of marked changes in color of the face, which is sometimes flushed, and at other times very pale. As the patient describes this symptom, "the color comes and goes." With the above

there is often a loss of appetite, and perversion of the same, the latter taking the form of a desire for articles of food having a decided flavor, such as pickles, acids, or even sweets of various sorts, and a disgust for meat in any form. In addition, certain objective symptoms will be observed in most cases, as follows:

There is a peculiar greenish tint to the complexion, which is rather characteristic of the lesion, and an anemia of the conjunctiva, and above all a decided waxy pallor of the ears. An examination of the heart usually shows an increased rapidity of contraction, with a soft blowing murmur transmitted along the arteries of the neck. Sometimes there is a slight edema of the lower extremities, most marked in the evening, and after walking or dancing. The pulse is rapid, from 90 to 120, or even more. A marked systolic murmur is generally present (hemic), transmitted upward along the carotid vessels. The tension of the arteries is in proportion to the rapidity of the cardiac systole. If the patient is asked to walk rapidly across the floor a few times, the rapidity of the heart's action is markedly increased.

The pathology of these cases is simple. If the coloring matter of the blood, or, in other words, the hemoglobin, is lessened, no matter from what cause, the amount of oxygen conveyed to the various tissues is necessarily diminished. As a result all the tissues of the body must suffer from insufficient oxygenation and the symptoms of this condition necessarily follow. I do not hesitate to assert that without the proper determination of the amount of hemoglobin in any case of apparent chlorosis, or simple anemia, or chloroanemia there is no more information to be obtained from the *apparent* condition than could be obtained in a case of typhoid without the use of a clinical thermometer, or the counting of the pulse-rate without the employment of a watch with a second-hand.

One more assertion I will venture to make is this: If a patient suffering from this condition, does not regain the full amount of hemoglobin, *viz*: 90-100 percent, it is only a question of time before a relapse follows. For the last four years I have employed the Hematometer of Fleischl to determine the amount of hemoglobin in these cases, and by repeated examinations have determined the exact condition of the patient and the amount of improvement under the treatment employed.

The method of treatment in these cases may be classed under the following heads: 1. Hygienic Measures. 2. Dietetic Measures. 3. Medicinal Measures.

1. *Hygienic measures.* These include directions as to proper clothing, the necessary amount of rest and the importance of observing regular hours in eating, sleeping, etc., and, above all, the avoidance of fatigue. Patients are induced to make this damaging effort by advice of friends, who say, "Take plenty of outdoor exercise, and you will be all right," and often the same advice is given by medical men. In either event the patient is only made

worse by following such suggestions. I also think that a complete rest for two hours in the afternoon is important and always order it. Late hours are forbidden, and I direct these patients to retire not later than 10 P. M. If attending school, I insist that the patient withdraw for a time.

2. *Dietetic measures.* The directions given are briefly these. Nourishing and substantial food is to be taken, and the articles that merely gratify the palate are to be avoided. By the latter I mean candy, pastry, ice-cream, pickles and all such edibles. Stimulants are seldom indicated as a food.

3. *Medicinal measures.* Iron in some form is almost a specific in these cases; hydrochloric acid is of value in many. I think certain principles should be considered in the administration of medicinal remedies. 1. The drug should be of such a nature that the patient is not likely to find the remedy repugnant in any way and rebel. 2. The remedy used should be prescribed to be taken at such a time that it cannot well be forgotten. To insure the latter, I order the remedy to be taken with or after meals. I am confident that there is nothing more irksome to this class of patients than to take medicine at frequent intervals. A manufacturer of an organic iron compound, in a personal letter, advised that his particular preparation be given every hour, or even oftener. The absurdity of such a step is too apparent to require any explanation. Imagine an anemic patient, a young girl of 17 years, taking conscientiously for several months a remedy every hour, or oftener! I am sure that most of our patients would seek other advice for their trouble, if given this order.

Of iron preparations, personally I prefer the sulphate of iron, in doses of from six to twelve grains daily, after meals. The sulphate is a ferric compound, therefore is regarded as more constipating than a ferrous compound. From experience and from careful experiment on this question I do not hesitate to assert that the sulphate of iron is decidedly laxative in its action, and to such an extent, that if constipation exists in a case of anemia, I order no laxative, trusting to this compound to overcome the trouble. At the same time I explain the importance of training the bowels to move at a certain time each day.

In most cases I order dilute hydrochloric acid in twenty-drop doses, to be taken in a glass of water with meals. In some cases pepsin is ordered in conjunction with the mineral acid. The administration of these drugs is not from any supposed specific effect, as the anemic condition has been supposed to depend upon a deficiency of hydrochloric acid in the secretion of the stomach, but entirely with the object of preventing the epigastric distress, so common in these patients, this distress resulting from the incomplete conversion of the contents of the stomach, before passing into the intestine. Unless the gastric contents are properly transformed they are sure to ferment or decompose in the small intestine and produce the systemic poisoning so characteristic of insufficient gastric digestion.



The results obtained from this plan of treatment are well shown in the appended list of cases. I wish to say that this list is not selected, but is merely quoted without regard to time or condition, to illustrate the statements contained in this paper. The number quoted is small, but they could be increased largely from my records, if necessary.

There is one very important precaution to be observed in treating these cases, that is, not to permit the patient to discontinue the iron as soon as the hemoglobin reaches the normal, or else a relapse is apt to result sooner or later. As an example, cases 5, 8, 10, 12, 14, show the result of the hemoglobin not being brought to the normal, and I am inclined to think that a sudden withdrawal of the iron would be apt to be followed by a relapse. My custom is to gradually decrease the dose, but have it taken for six or eight weeks after the patient is well. I have not known a relapse to occur under these conditions, unless the patient again became careless in habits.

#### LIST OF CASES

No. 1. Aged 19; no occupation; symptoms about 1½ years. April, 1895. April 13, Hgloboin, 25 percent; April 23, 99-50 percent; May 8, 70 percent; May 23, 80 percent; June 15, 100 percent; July 13, 100 percent. Weight at beginning was 98 pounds; increased to 105 pounds in two months.

No. 2. Age 18; clerk; duration over a year. December, 1894. Dec. 3, Hgloboin, 30 percent; Dec. 12, 65 percent; Jan. 8, 75 percent; Jan. 23, 85 percent; Feb. 13, 95 percent; March 13, 100 percent.

No. 3. Age 18; clerk; duration about six months. April, 1892. April 12, Hgloboin, 50 percent; April 22, 70 percent; May 6, 85 percent; May 27, 95 percent; June 17, 100 percent.

No. 4. Age 14½; no occupation; duration five or six months. June, 1895. June 7, Hgloboin, 45 percent; June 19, 60 percent; July 8, 95 percent. Patient lost sight of.

No. 5. Applied in June, 1894. Age 22; no occupation; symptoms dating back about a year. At that time the Hgloboin was 50 percent. Patient did not follow directions, and did not return. Next applied in November, 1895, for the same symptoms, and stated she had not followed my advice, but proposed to this time. I am glad to say she kept her promise and has been well repaid for her pains, as she is now perfectly well, which the following data will show: Nov. 26, Hgloboin, 50 percent; Dec. 10, 80 percent; Dec. 24, 90 percent; Jan. 7, 90 percent; Jan. 29, 100 percent; Feb. 25, 100 percent; March 27, 100 percent.

No. 6. This patient was a stout woman of 29, weighing 150 pounds. Seamstress. She looked remarkably healthy, and I was surprised to hear her symptoms, so totally were they at variance with her general appearance. For nearly a year she had eaten hurriedly and irregularly, and noticed a

gradual loss of appetite. Consumed a large amount of tea between meals, probably as a stimulant. Applied in January, 1895. Jan. 5, Hgloboin, 45 percent; Jan. 12, 65 percent; Feb. 12, 98-100 percent. She has been perfectly well ever since. I see her often.

No. 7. Age 16; no occupation; complaining eight months. A cousin of case 6. Applied June, 1895. June 17, Hgloboin, 60 percent; July 5, 80 percent; Aug. 6, 95 percent. Remains perfectly well.

No. 8. Age 35; seamstress; complaining for over a year; worse of late. March, 1895. March 3, Hgloboin, 50 percent; March 14, 65 percent; April 4, 80 percent. She did not return. I saw her eight months later for an acute illness, and from her history judge she had had a relapse.

No. 9. Age 16; schoolgirl. January, 1895. Symptoms for last four months. Jan. 24, Hgloboin, 45 percent, weight 100 pounds; Feb. 2, 65 percent; Feb. 16, 80 percent, weight 115 pounds; March 9, 95 percent; April 20, 100 percent. This patient looked like a different person at this time, so great was the change in her appearance for the better.

No. 10. Age 19; employed in a printing office; first applied in June, 1893; symptoms dated from fall of '92. All through the summer lived principally on ice-cream, cake, and soda-water, eating little of the proper sort of food at meals. Attended picnics and dances until compelled to forego them through sheer weakness. June 11, Hgloboin, 40 percent; June 25, 70 percent; July 23, 100 percent. In August, 1894, she returned, complaining of the same symptoms. Admitted being careless in diet as before, as well as not having sufficient rest and sleep. Aug. 24, Hgloboin, 50 percent; Sept. 21, 80 percent. She did not return, as directed. I next saw her in Feb. 1895. Feb. 11, Hgloboin, 50 percent; March 2, 80 percent. As before she probably felt perfectly well, and it was not necessary to return. I expect she will have another relapse in a few months.

No. 11. Age 16; schoolgirl; symptoms for about four months previously; applied in November, 1894. Nov. 1, Hgloboin, 45 percent; Nov. 10, 55 percent; Nov. 29, 75 percent; Jan. 12, 85 percent; Feb. 2, 95 percent; March 2, 98-100 percent; April 6, 98-100 percent. Early in December went home with a severe cold. This accounts for the slight improvement during the six weeks.

No. 12. Age 24; housemaid; symptoms came on so gradually that it was an impossibility to tell when they began. First applied in July, 1892, and was treated without any examination of the blood. She seemed to be perfectly well after three months' treatment. In Feb., 1893, returned with the same symptoms. The blood was then examined with this result: Feb. 17, Hgloboin, 35 percent; March 20, 70 percent; April 26, 85 percent. She thought she was perfectly well, so did not return as directed. About the end of 1894 she again began to suffer from the same symptoms, and finally

grew so distressed that she again applied for treatment. She seemed worse than in the former attacks, and an examination of the blood proved that she was worse. Feb. 7, Hgloboin, 25 percent; March 7, 75 percent; April 6, 90 percent; May 1, 100 percent. Examinations were made in July and September of same year, and the condition was found to be perfectly normal. She said she felt far better than she had for several years. This time she took the sulphate of iron in daily doses of six to ten grains. She has learned how to take care of her health, and I feel confident she will not suffer from this trouble again.

No. 13. Age 16; schoolgirl; symptoms of about seven months' duration. Applied in April, 1895. April 20, Hgloboin, 35 percent, weight 109 pounds; May 9, 30-32 percent, weight 104 pounds; May 23, 60 percent, weight 104 pounds; June 8, 75 percent, weight 107 pounds; June 25, 100 percent, weight 113 pounds.

No. 14. Age 17; schoolgirl; symptoms of five months' duration. Applied February, 1893. Feb. 7, Hgloboin, 30 percent; Feb. 25, 55 percent; March 27, 90 percent; April 27, 95 percent. This patient had a relapse from improper habits, and applied for treatment in February, 1895. Feb. 27, Hgloboin, 55 percent; May 3, 80 percent. This patient did not return, and it is probable that she will again suffer a relapse, like others who have not continued treatment until the blood showed a normal amount of hemoglobin.

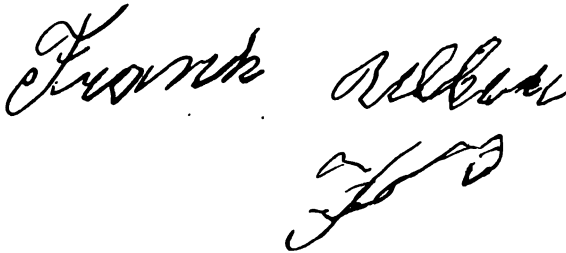
No. 15. Age 20; no occupation. This is the only case I have found where simple anemia was the result of a loss of blood. I think this condition is rare, and I venture to give a brief history of the case. She was confined in November, 1894. Delivery was followed by a profuse hemorrhage. She nursed the child until April of the present year, but never regained her strength. She had to abandon nursing, owing to lack of milk and continued exhaustion. Before marriage her weight was about 116 pounds; at present time (May 1, 1895,) is only 104 pounds. She suffers from severe dyspnea on the slightest exertion, and presents an appearance of extreme exhaustion and weakness. Pulse too rapid to count. Face and mucous membranes very pale. May 1, Hgloboin, 25 percent, weight 105 pounds, pulse 130; May 13, 50 percent, weight 109 pounds, pulse 92; May 23, 65 percent, weight 109 pounds, pulse 84; June 6, 65 percent, weight 109 pounds, pulse 80; June 21, 80 percent, weight 111, pulse 80; July 6, 90 percent, weight 114 pounds; July 21, 100 percent; Aug. 9, 100 percent; Dec. 20, 125 pounds, feels very well, and looks like a person in robust health.

## Two Cases of Disseminated Sclerosis and a Case of Jacksonian Epilepsy of Embolic Origin, with Presentation of Cases

BY CHARLES J. ALDRICH, M. D., CLEVELAND

*Neurologist to Cleveland General Hospital*

CASE I. At the instance of Dr. M. Rosenwasser this young man, F. U., consulted me, August 21, 1896. He is 29 years old, was born in Bohemia, and is a moulder by trade. He is married and the father of two healthy children. He has a good family history, denies venereal taint and has had no previous sickness. Last May he had a chill which was followed by fever and cough. He went to work not fully restored. On the first of June he quit work on account of growing weakness in his legs and a distressing paresthesia. At first the paresthesia, which consisted of a sensation of worms crawling beneath the skin, was confined to the left leg, but soon spread to the other extremities and trunk. He also suffered from pain in the occiput and back, and his hands trembled on movement. The weakness, pain, tremor and paresthesia have progressively increased. His tongue is furred, appetite poor, but the bowels are regular. He sleeps well and does not seem to worry over his condition. His speech is not changed. The first objective symptom we observe is an irregular jerky tremor of the hands. It is what the Germans aptly named "intention-tremor," a tremor which is brought out by voluntary movement. I will ask him to close his eyes and slowly bring his index finger to the tip of his nose. You observe that he starts quite well, but as his finger nears the nose the jerky incoordinate character of the tremor becomes so marked that it is only with the utmost difficulty that he succeeds. You may also notice a slight incoordination of both hands. Although left-handed, the dynamometer shows more power in the dexter member. He states that the left side has been the weakest and most painful. His sight is good, pupils normal, and there are no ocular palsies. He shows a well marked nystagmus. His signature, which I pass for your inspection, is characteristic. All forms

The image shows a handwritten signature in cursive script. The signature appears to read "Frank Uhler" and is written in dark ink. Below the main signature, there is a smaller, more stylized mark that looks like "F.U." or a similar abbreviation.

FRANK UHLER, CLEVELAND

of sensation are normal. Both knee-jerks are exaggerated; beginning ankle-clonus on both sides, double front tap and Achilles-jerk, and active plantar reflexes are noted. Both wrist and elbow-jerks are exaggerated, and a well-developed jaw-jerk, as you see, can be demonstrated. These positive symptoms of the case which you have seen demonstrated are enough to establish the diagnosis of disseminated or insular sclerosis. Let us summarize:

1. The tremor and its character.
2. The nystagmus.
3. The jaw-jerk, and increased muscle-jerks, with preservation of the plantar reflexes.
4. The general and increasing weakness and paresthesia.
5. His age.
6. The wide-spread evidence of disseminated irritation of the central nervous system, as shown by the multiplicity of phenomena due to small foci of organic change.

CASE II. This case was kindly referred to me by Dr. Axtell, of Sheakleyville, Pa., and this gentleman has obligingly consented to appear before you that we may observe how insidious and masked, disseminated sclerosis may sometimes appear. F. M. T. is 24 years of age, and a farmer by occupation. He has a good family history. He has been married six years; his wife has had pulmonary hemorrhages and a miscarriage from accidental cause, this being her only pregnancy. He gives no evidence or history of venereal infection. Pneumonia and a fractured clavicle comprise his former disabilities; neither has he been subjected to any unusual mental worry or fret. He has carried hard physical labor to excess. Last summer he suffered some gastric disturbance, and in March began to have headache, which increased in severity until he was forced to take to his bed. Once or twice during this headache, he vomited. The pain became continuous, and was general over the head and left side of the face, and the facial muscles of that side twitched. There was no periodical or diurnal increase of pain, but the least jar or movement caused exacerbations. No diplopia or localized weakness of any group of muscles was marked. He continually suffered from chilliness, slow pulse and subnormal temperature. After he got out of bed he found that his legs remained weak; he had dull occipital pain; precordial pain; alternating constipation and diarrhea; weak vision; and abnormal sexual excitement. This is practically his present condition. You may notice the marked blepharospasm; he shows no nystagmus or ocular palsies; the pupils are wide, round and equal, but react slowly to light. The optic discs are pale and show beginning atrophy. The perimeter shows contraction to form only. Dynamometer, right hand, 50; left hand, 45. Actual paralysis, anesthesia, hyperesthesia, or paresthesia, cannot be demonstrated in any part of the body. Both knee-jerks are in

excess; a beginning ankle-clonus can be demonstrated on both sides; the plantar reflexes are active; and both elbow and wrist-jerks are excessive. Even those at a distance can see the marked jerk elicited by a sharp blow of the percussion hammer on my finger which rests lightly on the teeth. A slight tremor and incoordination of the hands can be demonstrated. As he protrudes the tongue you can observe a very noticeable tremor of that organ. He has no incoordination of the lower limbs, but sways while standing with the eyes closed. He is considerably concerned as to his condition, but speech and mentality are unchanged. This case is more of a problem than the preceding one. 'The tremor is ill-developed, he has no disturbances of sensation, and the lack of nystagmoid movements lend to the deception. But the increased knee-jerks and beginning ankle-clonus, with active plantar reflexes, would stamp the case as probably organic; but when the jaw-jerk is added, we are almost sure of the correctness of the position, which the presence of optic atrophy assures us. A neurasthenic might show an increase of reflexes and even as much ankle-clonus as this case presents, but neurasthenia can furnish no such jaw phenomena as this case exhibits. In hysteria, where myotatic irritability is the rule, and knee-jerks and hysterical ankle-clonus are often met with, yet the jaw-jerks seem beyond the powers of this artful simulator. Besides, in hysteria the plantar reflexes are absent, and optic atrophy is no part of that disease.

CASE III. This little boy, Albert Wolf, is 9 years old, and one of four healthy children. His family history is good; and previous to an attack of rheumatic fever, two years ago, he enjoyed the best of health. Several joints were affected and he could not lie down. It was six months before he was able to be out of doors. About twelve months ago he was awakened in the morning by a clonic spasm of the right side of the face. His face was drawn to the right and the mouth held open. He was conscious but unable to speak on account of the spasmodic contraction and relaxation of the muscles of the face. After the spasm, which lasted several minutes, the muscles were relaxed, cold and paretic. Since then he has had many such attacks; which usually occur in the morning; only two or three exceptions have been noted. Once only did the whole right side share in the spasm. On this occasion it began in the face as usual and extended to the arm and forearm, thence to the trunk, thigh and leg muscles, until the whole right half of the body was in active spasm. Following the spasm the side was weak and useless for some little time. Separate and apart from this cortical epilepsy, he had attacks of vertigo, in which he turns pale and nearly falls from faintness. He neither stares, performs any purposeless movements, nor sighs after the attack. He has no headache, sleeps well, and is cheerful and bright in mind. He has never had any dropsy, splenic nor hepatic tenderness, but several weeks ago was jaundiced. The reflexes and muscle-jerks are normal. He is right-handed, but the dynamometer shows the

sinister member to be a trifle the stronger. All movements of the eye are properly performed and the discs and pupils are normal. This history is enough to establish the diagnosis of an irritative lesion of the lower third of the anterior and posterior central convolutions, which are known to control the muscles of the face, tongue, pharynx and larynx. That the lesion is irritative and not destructive is shown by the absence of paralysis or atrophy. It is well known that uremic convulsions may simulate Jacksonian spasm, but a few years ago I demonstrated the brain of a child that died of tubercular meningitis, who during life presented characteristic hemispasm. Professor Lowman observed this case with me. It is safe to diagnose an irritative lesion of the cortex when the spasms preserve their identity so long, and especially when they show their Jacksonian peculiarity of a definite order of extensions; thus, if the spasm begins in the face it continues until the whole face is in spasm; then the muscles of the shoulder, arm, fore-arm and hand are involved in the order of their mention. When we consider the nature of a lesion, we raise a question fraught with peculiar difficulties. Is it a tumor, a small area of softening, a small patch of sclerosis or a meningeal adhesion? These lesions are mentioned in the order of their frequency. The patient has not suffered from headaches, mental deterioration, cranial nerve palsies, or intraocular changes. The disease is not progressive. All of these are against the idea of a tumor. He has had endocarditis and is now suffering from the resulting valvular lesions, which are probably the cause of the spells of vertigo of which he complains. The jaundice may have been due to the disturbed circulation or to a small hepatic embolus. The logic of pathology teaches us that one of the small arteries of the cortex was plugged by a bit of fibrin derived from one of these crippled valves. The result has been, that a small part of the cortex has softened; and while not enough nerve-tissue was destroyed to prevent compensation, the focus of irritation is in a region of the brain where the slightest abnormality is apt to become a discharging lesion, which at periods will burst forth in uncontrollable muscular spasm in some definite set of muscles. His age is against a possible sclerosis, and we have neither history, evidence of injury nor meningitis to account for an adhesion of the meninges. The question of surgical treatment is of great interest, as cases are on record in which the evacuation of a small necrosis-cyst of the cortex has relieved Jacksonian spasm. We should also remember that a small irritation which last year caused but local spasm may have slowly grown, and the tolerant brain becoming accustomed to the inconvenience of the waxing intruder, performs its usual functions with the exception of these spasmodic protests, until the irritation becomes an actual destruction, and paralysis supervenes. While we may not hope to "heal a hole in the brain by making another," yet a good surgeon will neither jeopardize the life of his patient nor increase the malady by a simple trephining and evacuation of the cyst contents. Yet this simple and safe measure might rescue this bright boy from the barren life of an epileptic.

744 Prospect Street

### Three Cases of Intubation of the Larynx

BY T. H. BRANNAN, M. D., CANAL DOVER

IT is not my purpose in this report to announce a new therapeutic discovery, or a brilliant surgical achievement, but simply to add my experience to that of others, in the treatment of a condition that is almost daily coming before some of us.

It is only by the sum total of our varied experiences that we are enabled to arrive at the correct value of any plan of treatment or surgical procedure, that we determine the rate of mortality, or percentage of recoveries.

Those who were present at our last meeting in Canton will remember that in the discussion following the report of Dr. Walker's cases of intubation a prominent member of the Society spoke discouragingly of the operation. His experience had been such as to lead him to believe that nothing was to be gained by operative procedure. This is doubtless the feeling of many other physicians, whose first experience in the operation has been unfavorable; but if intubation is followed up in all cases that are threatened with death from laryngeal stenosis by the formation of false membrane, they will in time come to regard the operation more favorably. Recent statistics taken from hospital reports place the range of recoveries from intubation in diphtheritic stenosis in round numbers from 30 to 50 percent.

My experience in private practice has given a rate of recoveries a little in advance of that reported from hospital work.

This experience, coupled with what was said in the discussion of the subject at our last meeting, has prompted me to report three cases operated on since that time.

These three cases were all in the practice of other physicians; two in the practice of Dr. Sawyer at Mineral Point, and one in that of Dr. J. A. Hobson at Flushing, Belmont County. Dr. Sawyer's cases were both boys, aged respectively six and eight, and both recovered, while Dr. Hobson's case was a girl two years and four months old, who died from exhaustion 30 hours after the removal of the tube.

Relative to Dr. Sawyer's cases, he writes me as follows:

#### DETAILED STATEMENT OF THREE CASES OF DIPHTHERITIC CROUP

June 27. While passing the home of J. G. Giles, I was called in to see his son Anson, who had been hoarse for two or three days and complained of his throat being a little sore. After making an examination I concluded that the boy was taking scarlet fever (I had two very severe cases in the neighborhood at the time), and prescribed accordingly. The following day the father informed me the boy was better, but that his two-year-old daughter was not feeling well, and the same evening I was called to see her. I found her

*Read before the Union Medical Association of Northeastern Ohio, August 11 1896.*



temperature 102.5°, and a slight swelling of the tonsils, but no membrane on them. There was a marked hoarseness, but the breathing was free and easy. The morning of June 29 her condition was about the same, but in the afternoon of the same day she sank very rapidly and died. I attributed her death to blood poisoning of scarlet-fever origin. During my visits I saw the boy, Anson, playing around the house and yard, and, in reply to my inquiries, said he was all right. On July 3 I was called to see him and found him laboring for breath and suffering from a diphtheritic sore throat. On the morning of July 4 the patient was much worse, and I advised intubation at once as the only chance for the boy's life. After getting the consent of the parents I telephoned Dr. T. H. Brannan, of Canal Dover, who promptly responded, and, concurring in my diagnosis and belief that intubation was the only means of relief, proceeded to insert a tube, which was soon accomplished, to the great relief of the patient. The tube was allowed to remain in for nearly four days, when, in a paroxysm of coughing, it was expelled. As his breathing was so much improved it was not deemed necessary to repeat the operation, and at this date he has fully recovered and speaks as loudly and plainly as before his sickness.

July 7 I was called to see the six-year-old son of George Zimmer, who lives near the Giles family, and found every indication that a like condition to the Giles' boy's prevailed. After waiting two days in hopes medical treatment would be sufficient, I was again obliged to send for Dr. T. H. Brannan and have him perform intubation. The relief in this case was as quick and marked as in the preceding one, but at the end of the second day the tube was expelled and a larger one was then inserted, as the trouble had not yet abated. This second tube remained in two days and was then expelled, and I found it completely filled with a solid membrane. As his breathing was better, and fearing the membrane was lower down than the tube would reach, it was decided to wait a few hours before replacing the tube. The patient commenced to improve and now we regard him as practically out of danger.

We are now satisfied that the little girl of Mr. Giles had the diphtheria poison, and regret that we did not use antitoxin, for at no time was intubation indicated.

In conclusion I can only say that I cannot speak in too great praise of the intubation operation, and the parents and patients in the above cases where used are firm believers in its efficacy.

Respectfully yours,

C. H. SAWYER, M. D.

Mineral Point, O., July 21, 1896.

In the Giles' boy, eight years of age, the breathing was labored and characteristic, face pale, temperature 102°, pulse 140, and the deposit very marked upon both tonsils and the posterior pharyngeal wall, a large mass of which was removed by the guiding finger on the first attempt at introduction of the tube. So much resistance was met with in this boy that it became necessary to tie him and the nurse in the chair and to entrust his legs, also tied, to a second nurse before he could be controlled sufficiently to manage him. A marked improvement in the respiration soon followed the introduction of the tube. The convalescence was uneventful, the tube being

coughed out at the end of four days, when the obstruction to respiration was found to be permanently relieved.

The six-year-old Zimmer boy was a brighter, better-nourished patient, with the constitutional symptoms a little less marked than in the other case, but he had the characteristic cough and labored inspiration as noted in the other boy, with the deposit plainly visible upon both tonsils. But little trouble was experienced in placing the tube.

At 10 P. M. the second day, it was expelled by coughing, and as it was thought the boy would be dead before a messenger could bring me to his bedside, none was dispatched. He struggled through the balance of the night, however, and when an early train carried me to him in the morning, it was at once plainly visible that the patient had greatly lost in strength and vitality from the time of first intubation. Preparations were hurriedly arranged and a larger tube was successfully placed upon the first attempt. The little fellow almost at once experienced marked relief from his extremely labored respiration. As stated by the doctor, two days later he again extubated himself in a fit of coughing, when relief was found sufficient to render reintubation unnecessary. His further convalescence was uneventful.

Dr. Hobson's case. I was called to see this little girl, 2 1-3 years old, on a Friday evening. She was the first and only child, and the parents were very solicitous for her welfare. She had been sick for three or four days with fever and sore throat, with gradually increasing laryngeal stenosis. She was not rugged in appearance. Her pulse was 130, temperature ranging from 101° to 102°, tongue heavily coated and a deposit plainly visible upon the sides of both tonsils, which were markedly enlarged and proved a troublesome obstacle in the way of intubating. On the first attempt, however, a tube was passed into the larynx. It remained but a moment, however, when it was coughed out. After a few efforts the same tube was reintroduced, but was soon coughed out again as before. A larger tube was then selected, and after a few more efforts, nine in all I was afterwards told, the tube was permanently placed, and, after the cough that always follows the introduction had subsided, she called for her cradle and went to bed, much relieved from the labored respiration. I heard from her almost daily by letter, and she did well until the following Thursday at 1 P. M., when the tube was removed. At the time of removal the tongue was still heavily coated and the deposit still visible on the sides of the tonsils. Though the temperature was not noted at this time, the dried condition of the lips indicated that some febrile action was still present. Immediately following extubation the respiration was seen to be still roughened and suspicious. Having about four hours between trains I went with the doctor to his hospital to assist him in an operation he had arranged for that afternoon, but inside of two hours a messenger was dispatched in haste, saying they thought the child was dying.

Upon again arriving at the house, it was plainly to be seen that the child would have to be reintubated.

Preparations were made and the child again placed in the lap of one of a number of neighbor women who were present, when some delay was occasioned in order to quell a commotion that was going on in the back part of the house and yard, in which the father was heard to say "that he would shoot that doctor if his child died."

At the time I got back to the patient its condition was alarming; the face was cyanotic, lips and finger-nails purple, and it was gasping for breath as the great beads of perspiration rolled down from its face and forehead. An effort was quickly made and the tube securely placed upon first attempt. But a few moments elapsed until the child's face assumed its natural color, the labored respiration was relieved and the child called for its cradle.

An hour later I left for home, and heard nothing further from the patient until the following Monday, when I received this letter from the doctor:

Flushing, Ohio, July 27, 1896.

Dear Doctor:—The little patient died last night at twelve o'clock from exhaustion. I fed her the best I could and gave tonics and stimulants freely. Saturday evening the tube got stopped up and she could not breathe at all for a little while; lips purple. I removed the tube and found it filled with mucus and false membrane; after that she did not suffer with difficult respiration. Other patient is doing well.

In haste, yours,

J. A. HOBSON.

This patient died from exhaustion some thirty hours after the condition for which she was intubated was relieved, and I shall always feel that she might have recovered if she had had the proper nursing and supportive treatment, which I am satisfied that she did not get.

This gives me one death out of the last four intubations, and a total of three deaths in eight cases, or 62½ percent of recoveries.

The three deaths occurred in females while the five recoveries were all males.

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## Extreme Cases of Pelvic Abscess, and a Method of Treatment

BY WM. H. HUMISTON, M. D., CLEVELAND

*Associate Professor of Gynecology Medical Department Western Reserve University*

MRS. N. J., aged 22 years (widow), was admitted to the hospital (City) July 18, 1896, and gave the following history: Her father is 53 years old and in good health, and the mother is of the same age but of a neurotic temperament. There are no hereditary tendencies in the family.

Personal history: In childhood the patient had diphtheria, scarlet fever and measles, and at the age of 16 years had a severe attack of "inflammation

*Reported to the Cleveland Medical Society, September 11, 1896*

of the bowels," complicated by both kidney and bladder disease, but gives no history either of gonorrhea or syphilis. She menstruated for the first time at the age of 14 years, the catemenia appearing regularly without pain, lasting two days and scanty in quantity. Since she had pelvic peritonitis or "inflammation of the bowels," she has experienced great pain and has had many recurrences. She never has been pregnant. Her last attack, April, 1896, started with a chill, followed by fever. The abdomen became very tense and painful, with severe sharp pains in the pelvis. Headache and backache were constant and she rapidly lost flesh and strength. Since the second week of her illness she has passed at intervals large quantities of pus by the bowel. Her general appearance when she was admitted to the hospital was that of a case of *extreme* septic poisoning.

Her temperature ranged from 99° F. each morning to 103.5° in the evening, and the pulse from 98 to 120 beats per minute. She was unable to walk upright and the effort was attended with much pain. The examination of the urine was negative, excepting for indican, which was found to be constant. The average daily quantity of urine was as low as 10 ounces.

An examination of the pelvis revealed a large mass filling the space to the right side of the uterus and extending into the belly half way to the umbilicus. The abdomen was exceedingly tender and tympanitic, so that palpation revealed but little. No fluctuation could be determined through the vaginal wall. After a week's preparation, during which time particular attention was given to increasing elimination by the kidneys, toning of the heart's action, disinfection of the upper bowel by daily catharsis, and washing of the lower bowel, the patient was anesthetized and celiotomy was performed, another vaginal examination under chloroform having failed to give in any part of the mass a sense of fluctuation.

Immediately underneath the incision through the abdominal wall the fundus of a fluctuating mass presented, which proved to be an abscess with thick walls. The adhesions round about were very vascular, and, after enlarging the wound, the intestines were found to be firmly matted.

A small trocar with a cannula was introduced and eight ounces of creamy pus with a fecal odor were evacuated. An incision was then made into the mass. The abscess cavity was carefully wiped with pledgets of cotton soaked in a strong bichlorid solution and then packed with gauze. The edges were stitched to those of the abdominal wound. The abdominal incision was closed and the patient quickly placed in bed. During the operation the patient's pulse was 140 and very weak.

On the evening of the second day her temperature reached 101.6°, the highest point during convalescence, and on the fourth day was 99°, with a pulse of 90.

Considering her condition at time of operation, her convalescence has been very rapid. She has gained in weight, is of good color, eats and sleeps

well. For several weeks great quantities of pus, still with a fecal odor, were discharged, but the cavity is now almost closed and only a small, healthy, granulating surface is left, with no evidence of the former communication between abscess and intestine.

This case and one upon which I operated last winter, in which the pelvic abscess reached enormous proportions, containing 110 ounces of pus, demonstrate what can be accomplished in these greatly reduced septic patients by not attempting to do a so-called complete radical operation.

The vital strength of both patients was extremely low and they could not have endured a long operation, and the separation of extensive vascular adhesions, exposing large tracts of raw surfaces to the danger of becoming septic areas and quickly overwhelming the already greatly enfeebled general system.

The method adopted was to only uncover the abscess; to pack sterilized gauze well over all exposed viscera; to aspirate the contents; to enlarge the opening to one of good size; to thoroughly wipe out all remaining contents; to pack the cavity full of gauze; to stitch the abscess wall to the abdominal incision; and you are master of the situation.

The first case has now been absolutely well in every respect for six months, and performing all her duties without a symptom of her former trouble. The recent case has progressed to a degree that enables us to predict for her also a complete recovery.

We shall undoubtedly meet cases of this nature in which a complete recovery will not take place until after a secondary operation, but the primary operation will relieve the system of sepsis, and in a little time the general condition will be so greatly improved that the risks of a radical operation will be reduced to the average degree.

*129 Euclid Avenue*

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## The Importance of Making Examinations of the Sigmoid Flexure of the Colon

BY A. B. WALKER, M. D., CANTON

THE sigmoid flexure, as you know, is the double curve the descending colon takes before it terminates in the rectum. Treves claims "that it is not usually like the capital S shaped, but a large loop about 17½ inches long, with the top of the loop sometimes even touching the right side of the pelvis." In two cases in which I opened the abdomen and found

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the disease in the sigmoid, in one, the loop, as Treves calls it, extended over to the right side, and in the other it was lying in the median line. The upper part of the sigmoid is retained in its place by a loose fold of peritoneum, which accounts for its free movement and the different shapes it assumes. But at the lower end of the flexure the fold of the peritoneum is quite short, and holds the part up close to the sacroiliac symphysis. The sigmoid hangs down in the pelvis like a sac when not distended. The rectum is narrower where the sigmoid flexure joins it than further down, even narrower than the lower part of the sigmoid flexure.

From a mechanical standpoint the danger of feces accumulating in the double curve or loop is plain to be seen, with the opening in the rectum smaller than the sigmoid. But we do not mean to reflect on the mechanical construction of the sigmoid, for it has a wise and important function to perform, that of being a receptacle for the final disposal of the feces between the acts of defecation, as well as by its peculiar shape, to prevent the too rapid passage of the feces and gas from the bowels. The function of the rectum being to carry off the feces and not retain them, as is generally supposed, when the daily evacuation from the bowels is not observed. O'Beine claims that the main portion of the mass is lifted back into the sigmoid flexure, when the desire to go to stool is not attended to, thereby leaving the rectum comparatively free from feces. While this may be true, I know that I have often found, while making vaginal examinations, that the rectum was filled with a large fecal mass, but how long this mass had been in the rectum I could not say, or whether it was lifted back into the sigmoid flexure before its final expulsion, I do not know.

In the male I have rarely found feces in the rectum to any considerable amount. When the feces are lifted back into the sigmoid and retained there, the watery portion is soon absorbed and the accumulated mass acts as an irritant, thereby causing congestion, inflammation and ulceration of the mucous membrane, and as the hardened mass is finally forced out through the rectum it causes hemorrhoids and many other pathologic conditions of the rectum. But as I wish to confine my paper to the sigmoid flexure, will leave the disease of the rectum out.

There is no doubt that the sigmoid flexure is the most common seat of obstruction in the bowels, and it is well for us to keep in mind the loop shape that the sigmoid is likely to take when we feel a hard mass in the median line, or even on the right side.

Case 1. Four years ago I made an exploratory incision in the abdomen for what seemed to be a large fibroid tumor. In fact, it was so diagnosed by several of my medical friends. But when we got the abdomen open, to our surprise it was the sigmoid flexure lying in the median line and enormously distended with feces. The gut was hypertrophied, that is, its walls were quite thick, seemingly  $\frac{1}{4}$  inch, with a channel around the mass to allow

the feces to pass. We made a four-inch incision in the bowel and scooped out 15 to 20 pounds of hard feces, as well and thoroughly packed as the clay in the ground. This opening in the bowel was closed with 16 Czerny-Lembert silk sutures and dropped back into place. She made a good recovery and in eight months gave birth to a healthy child. This case gives the history before the operation of having had this supposed fibroid for eight years and that before she noticed it, she had suffered from constipation, but during the later years her bowels had been loose.

Case 2 was that of a married lady, 38 years of age, who had pain in her left side, endometritis and internal hemorrhoids with a mucopurulent discharge from bowels. She had a cachectic look, as though there was absorption of some septic material which was attributed to the condition of her uterus. Dilating, curetting and packing her uterus cured her endometritis, dilating her sphincter *ani*, and removal of her hemorrhoids cured her rectum, but the pain in her side and discharge from her bowels continued, and the cachectic appearance was no better.

Case 3 was that of a single lady, aged 24 years, who had pain in her side and back, dysmenorrhea, a small fissure in her anus with a mucopurulent discharge from her bowels. Dilating her uterus helped her dysmenorrhea, and dilating her sphincter and curetting the fissure cured her rectum, but the pain in her side and back and mucopurulent discharge were no better.

Case 4. A married lady, 48 years of age, had pain in left side and back, a rectal ulcer, several enlarged *papillae* and also a mucopurulent discharge streaked with blood from her bowels. A thorough dilation of her *sphincter ani* muscle, and curetting the ulcer, clipping off of the *papillae* cured her rectal trouble, but she still had the discharge from the bowels. About two weeks after the operation she remarked to me that she believed her disease was higher up and that I had not reached it. I tried to pass a Kelley's long rectal speculum without an anesthetic, but failed. I succeeded in passing a Wales Bougie No. 5, and thoroughly washed out her sigmoid flexure with hot water, after which I threw up into her sigmoid, through this same bougie, four ounces of a saturated solution of boric acid, which she retained six hours. This treatment was repeated every other day for a period of one month, when she was discharged cured. The pain in her back and left side were entirely relieved and the discharge from her bowels stopped. My experience in Case 4 enabled me to see where I had failed to cure cases 2 and 3. No. 2 was placed on the same treatment and is getting well. No. 3 is not well yet, but is improving. I may have to anesthetize her and explore the sigmoid flexure with a long speculum, when I expect to find an advanced stage of inflammation of her sigmoid, and perhaps some ulcerations.

Case 5. A married lady, aged 28, mother of one child, consulted me last winter for what she called indigestion, pain and tenderness over the left side, and distension of bowels from gas. She had a mucopurulent discharge,

mixed with blood from bowels, with at times round casts an inch or more long, not unlike the false membrane of croupous laryngitis. My diagnosis was inflammation of the sigmoid flexure, bordering on ulceration, with some narrowing of the bowel near the entrance to the rectum. I recommended an exploration with Kelley's speculum and later the use of a Wales bougie, as in case 4. My advice was not taken and later on a specialist was imported, who, in my presence, dilated and scissored her rectum; dilated, curetted and packed her uterus; dilated and removed a circular ring from her urethra; dehooded her clitoris and removed both her ovaries, all at one time in the order I have mentioned. I was not able to see anything specially wrong with her ovaries, but as we look through differently colored glasses, perhaps I was not the best judge. She recovered from the effects of the multiple operations, but was not benefited by them. In fact, her condition was made worse by the mutilations, which only added to her sufferings. A few weeks later, there being some induration in her pelvis, her specialist decided to remove her uterus, which he did through the vagina. After he was through he remarked to me that this ought to benefit the patient, when I told him that I had no confidence in it, for the trouble was in her sigmoid. He then passed a good-sized probe up into her sigmoid with considerable difficulty. She recovered from this second operation, and since having her sigmoid opened up, she has been somewhat better, but is not well, for on the 8th of this month I saw her in a very severe attack of indigestion, with the same trouble in her left side. I doubt whether she will ever get well until her sigmoid is opened up, cleansed and treated.

Case 6, that of a married lady, aged 27 years, mother of two children, a very intelligent lady, consulted me three months ago for what she called dysentery. Upon closer inquiry I learned that frequently through the day she would pass large quantities of mucus mixed with blood and pus. She had some tenderness over the sigmoid and pain in her back; was growing thinner in flesh and had a bad color. Trouble of her left ovary had been diagnosed by another physician, and her uterus had frequently been treated locally for the pain in her back. I was not able to find anything wrong with her uterus or ovaries, and her rectum looked fairly well, but when I passed a Wales bougie, as the point of it entered her sigmoid, it gave her a sharp pain in her back. My diagnosis was, advanced stage of inflammation of her sigmoid, bordering on ulceration. She gave the history of having been of decidedly constipated habit. My treatment consisted in *cascara sagrada*, to regulate her bowels; hot water enemas, to wash out her sigmoid, and fluid hydrastis, drams 2, water oz. 2, mixed, which I threw up into her sigmoid with a Wales bougie No. 5, every other day, after the enema passed off. This she retained from six to eight hours. She rapidly improved and is today comparatively well. She has no pain in her back and does not pass any more mucus, blood or pus.



I have purposely avoided malignant diseases, torsion, etc., of the sigmoid, because they are not usually hard to diagnose, and have given you the ones that are likely to be overlooked and treated for some other disease, which is more likely to be the case in the female, for when they have pain and distress in the pelvic region it is usually referred to the uterus or ovaries; and there is no doubt that many an ovary and uterus has been sacrificed when the pathologic condition was all in the sigmoid flexure.

## Intestinal Antisepsis in Typhoid Fever

BY D. S. HANSON, M. D., CLEVELAND

I HAVE been treating typhoid fever for quite a long time (four or five years) by the use of intestinal antiseptics, preferably by naphthalin, iodoform, charcoal, betanaphthol, salol, sulphocarbolate of zinc or salicylic acid. Just how much benefit my patients derived I am unable to say, but believe the severity and progress of the disease have been favorably modified thereby. A little more than a year ago the very favorable reports from the so-called antiseptic and eliminative treatment attracted my attention, and when asked to read a paper before this Society I gave as my subject the above method of treatment, and lay in wait for the first case to present itself, which occurred August 8, 1896.

All cases were put in bed on liquid diet and the ventilation regulated. I will say before going into details that all the cases here considered were typical and undoubted cases; all had rose-spots, continued fever higher at night, slight bronchitis and tender spleens, with hepatic congestion and iliac gurgling, so I will give only temperature, pulse and number of stools.

Case 1. William P., age 31, carpenter; temperature 104°, pulse 84. I prescribed Woodbridge typhoid tablets No. 1, made by Parke, Davis & Company, one tablet every half hour; the next day the temperature was 104.4°, the pulse 83. I then prescribed tablets No. 2, one every two hours, until the seventh day, when the temperature was 103°, the pulse 83. At this time I prescribed soft capsules, one every two hours, which he took in gradually diminishing quantities until the seventeenth day, when his temperature was normal. The number of evacuations was from two to five daily; the purgative effect was not at any time marked.

Case 2. September 1, 1895, Jennie S., age 32; temperature 102.6°, pulse 90. I prescribed tablets No. 1, one every half hour for three days. At this time the temperature was 103.6°, the pulse 108. I then prescribed tablets No. 2, one every two hours until the sixth day, when the temperature was 102.6°, the pulse 103. She began taking soft capsules, which she took for three days, with slight reduction in temperature and pulse-rate. At

*Read before the Cleveland Medical Society, September 11, 1896*

this time she said that the constant taste of the capsules was simply insupportable and she refused to take any more; so we gave her four grains of sulphocarbolate of zinc every two hours, and the case seemed to progress fully as favorably as before. Her bowels acted from two to four times daily while using the tablets. The temperature was normal on the evening of the eighteenth day.

Case 3. September 8, 1895. Emma W., age 8. Temperature 101°, pulse 135. Tablets No. 1 were given, one every hour for three days, when the temperature was 102.8°, the pulse 140. Tablets No. 2 were given until the end of the sixth day, when her temperature was 103.4°, the pulse 130, the heart-action weak. The patient could not swallow soft capsules and was given elixir of bismuth, pepsin and strychnin with a stimulant. At no time subsequently was either temperature higher or pulse faster than at this time. The evening temperature was normal on the twenty-second day. The bowels were constipated all the time.

Case 4. September 28, 1895. Henry B., age 24. Temperature 104.6°, pulse 108; was very sick. I prescribed tablets No. 1, one every half hour. On the second day his temperature was 104.6°, the pulse 99. He had seven movements of the bowels. The treatment was continued. On the third day the temperature was 104°, the pulse 104; the bowels acted 13 times, surely sufficient elimination; so I prescribed soft capsules, omitting tablets No. 2, owing to the successive purging. At the end of the fourth day the temperature was 105°, the pulse 108; he defecated five times. Strychnin was given and the soft capsules continued. On the fifth day the temperature was 106°, the pulse 124. He defecated three times and was very greatly exhausted. I advised Brand baths, but as no help could be obtained at home, advised taking the patient to the hospital. Another physician was called, and after another twenty-four hours, he advised them to take him to a hospital where he died the following day.

"One swallow does not make a summer." Four cases are not enough to draw positive conclusions from, but they cannot help to make some impression. First, regarding elimination. It is as old as medical literature, and many a time, while eliminating the germs and toxins, the patient has been eliminated also. Homeopathy in its early history owed the success it had largely to the fact that typhoid patients did better upon water alone than upon the purgative treatment then in vogue. Typhoid patients who are constipated do not die. Churchill, in giving statistics of thousands of cases in England and France, says not a death occurred in those cases in which the bowels were inactive. To me it seems a bad thing theoretically to constantly excite peristalsis in an inflamed and ulcerated bowel, and practical results sustain the theory. The old notion of our fathers that purgatives were harmful in this disease was learned at the cost of many lives, and we should heed their warning and give our patients the benefit thereof. As far

as intestinal disinfection goes there is no doubt that, as ordinarily used, it does little toward lessening germs and toxins, yet used after the method of Bouchard, by administration of iodoform and charcoal (iodoform 1, charcoal 100) the toxins of feces and urine can both be diminished markedly as shown by chemic and physiologic tests. Can we successfully attack the morbid agent of this disease? We would answer yes, that part of it in the alimentary tract to a limited extent. Bouchard succeeded in deodorizing feces by giving naphthalin (naphthalin five grams, mixed with an equal quantity of sugar, made aromatic with one or two drops of bergamot and divided into twenty powders, one every hour). Admitting that much can be done in this way, the question arises is this the best method to treat this disease? My answer would be, in mild cases, probably yes. In severe ones it does not compare favorably with the Brand treatment.

I would say in conclusion, that from the results of the cases here reported in connection with those seen before and since, antiseptic treatment without purging for mild cases, and Brand baths for severer ones is about the best in sight.

1419 Broadway

## Report of Three Cases of Uterine Fibroids Complicated by Pregnancy

[ABSTRACT]

BY M. ROSENWASSER, M. D., CLEVELAND

THE writer shows that, previous to the advent of abdominal surgery and of aseptic midwifery, the majority of mothers and of children died during or after labors, complicated by fibroids. The same mortality rate prevailed whether the labors were terminated naturally or by normal or instrumental aid. Since the new era the results have materially improved as to the number of mothers and children saved. The number of recent cases hitherto reported is, however, insufficient to formulate fixed rules. Each case must be treated on its own merits. He reports three cases in detail.

The first was a multinodular fibroid complicated by a pregnancy of five and one-half months. The rapid growth of the tumor and the suffering of the patient demanded interference. Suprapubic hysterectomy was performed. The patient died septic; infection being due to a preventable cause.

The second case was seen when pregnant four months. There being no probability of hindrance in the pelvis during labor, the case was allowed to go to term and was delivered of a living child. The tumor subsequently causing severe hemorrhages and pain, hysterectomy, nine months later, was followed by prompt recovery.

The third case was pregnant four months when seen. The tumor occupied the lower uterine segment. The cervix was displaced behind the pubes. Abortion had already been unsuccessfully tried. The patient was unwilling to delay until after viability of the child. Suprapubic hysterectomy was followed by ideal recovery.

Photographs of the specimens of the first and third cases were presented.

*Read before the American Association of Obstetricians and Gynecologists, at Richmond, Va., September 23, 1896*

722 Woodland Avenue

# Cleveland Journal of Medicine

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AND OF THE UNION MEDICAL ASSOCIATION OF NORTHEASTERN OHIO

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## EDITORIAL

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### Newspaper Medicine

WHEN the newspaper essays to inform its readers upon medical subjects it almost invariably makes itself ridiculous to cultured people, whether they have any medical education or not. The *Boston Transcript* has lately attempted to give its readers some information in regard to tuberculosis, and has succeeded very well in dishing up as modern, views which were held by the profession twenty years ago. Instead of going to some of the eminent physicians of Boston, or to any well-trained medical man or to a modern work upon the subject, it draws its inspiration from an article in the *Medical Brief*, by Dr. William B. Hidden, who up to the present time has been what his name implies in Boston. Dr. Hidden says consumption is caused by indigestion; that bacteria attend decay as a product, never as a cause; that the theory of a tubercle bacillus "is justified neither by heredity nor environment" (save the mark!); that Negroes in the south-

ern states never had phthisis while they were slaves; that the arterial circulation is minutely divided only in the apex of the lungs; that tubercles are collections of undigested matter gathered by the lacteals from the intestine; that tubercles are never deposited in the throat and lungs after maturity; and, finally, but most important, that the writer, the now fully discovered Dr. Hidden, has been a throat and lung specialist for 25 years.

As well may be believed not much now remains to be said. One wonders if the *Transcript* got value received for so valuable an advertisement or whether its business manager was as gullible as its editor.

There is a little more, however. The *Transcript* says: "As a supplement to Dr. Hidden's article, the editor of the *Medical Brief* appends the following terse and emphatic statement of the cause of consumption and the best methods for its treatment:

"'Consumption is not a contagious disease. Consumption is not a germ disease,' " [and so forth, *ad nauseam*].

This advice is so direct and full of common sense that it deserves to be preserved by every family, and faithfully followed if ever the dread disease should make its appearance."

The ridiculous position of the newspaper is much enhanced by the fact that, in addition to the indiscriminate headlong tumble of the editor of the *Transcript* into this pitfall of silliness, the presumably sagacious editor of *Public Opinion* approvingly reprints the article!! Really, we had thought better of *Public Opinion* and credited it with editorial discrimination, at least sufficient to distinguish between original matter and advertising, or to recognize as not new ideas which have been discarded these many years.

Could anything show more clearly than this how well it pays for the profession to support (to the tune of over 30,000 subscribers, so-claimed) journals which misrepresent it at every step and aid in spreading false impressions of its every advance? The newspapers may be condoned, perhaps, by saying they are ignorant, even though willingly; but the medical journal has no excuse, and the physicians who support it in luxury contribute heavily to that inertia of ignorance which retards our profession in common with less fortunate mankind.

We may, perhaps, be pardoned for saying in closing that the profession may rest assured that the originator of all this guff Will B.(e) Hidden from the scientific world as effectually to posterity as he has been to his contemporaries for the past quarter of a century.

\* \* \* \* \*

There is a practical and much more serious aspect of this circulation by the newspapers of antiquated views in regard to contagious diseases.

What would the general public even think of a newspaper which would teach that smallpox, scarlet fever, diphtheria, measles, etc., were disorders of digestion? There can be but one answer to the question because the public, in enlightened nations, well knows the contagious character of these diseases and the necessity for isolation, though of course the ignorant portion of the community can still be only effectually reached in these matters as in many others by the strong arm of the law.

After decades of unremitting and almost thankless toil; after the sacrifice of more than one highly valuable life, the medical profession has in recent years been enabled to demonstrate the contagiousness of tuberculosis as clearly as that of the other diseases mentioned, and is now actively engaged in the altruistic work of teaching the community at large the measures necessary to prevent the spread of the disease which is the cause of 25% of all deaths in this country. Then to have the benighted followers of introspective science step in and endeavor to block all progress by a dogged advocacy of long-since-exploded theories is distressing to the conscience of the profession and, far worse, is distinctly dangerous to the life and health of the community. In justice to its own high aims the medical profession must actively combat these fomenters of heresy and cease the support of everything which clogs the wheels of progress.

A newspaper article which leads the public to disregard the teachings of the profession of today and urges it to neglect all precautions aimed at the prevention of the spread of tuberculosis is distinctly dangerous to the life of the community. In regard to the article sketched above, every physician knows and admits that malassimilation furnishes very commonly the soil suitable to the growth of the tubercle bacillus in the tissues, but subjects so predisposed could not acquire tuberculosis if they were removed from every chance of infection. Every physician has seen robust individuals with good digestion succumb in a few short weeks or months to a virulent attack of the bacillus of tuberculosis, and the concealed author himself, with remarkable temerity, marshals the fact that in the case of cattle the healthy, robust-looking cows are just as liable to succumb to the disease as the more poorly-nourished ones.

We can only live in hopes of the time when the lay journalist can keep pace with the advances of medicine and can discriminate between true and false progress. Until then the profession "expects every man to do his duty" in spreading the truth.

## A Tale of Fits

A COPY of one of the daily papers has recently fallen into our hands from the far-off city of Columbus and we have examined it with much interest. It seems that medical and scientific articles are there given out in the public prints, simply to enlighten and educate the people. This must be ethical and right in that distant city, for a long and interesting account is in this newspaper flaunted on the first page among the mark-down sales and the consultations-free, of an operation by Dr. R. Harvey Reed, editor of the *Columbus Medical Journal*, and member of many learned societies. This case is so fraught with interest to the medical profession that we are impelled to give a few of its salient features. A fact of the greatest scientific importance is that Dr. Reed himself paid the patient's car-fare to the city and performed the operation free of charge. The poor sufferer had some years before been handling a pistol of the didn't-know-it-was-loaded variety, and, having previously mislaid a cartridge in the weapon, a bullet was deposited in his frontal bone, having first, we are led to believe by this veracious chronicle, made a tour of the brain. After some time the man became epileptic, or, in short, he had fits. We are sorry that we cannot give our readers the benefit of Dr. Reed's dissertation on epilepsy, or the remarks in full of one of the other surgeons present. They were sufficiently explicit to enable other sufferers from this trouble to recognize it and apply to Dr. Reed while there is yet time; suffice it to say that the "eminent Professor of the Principles and Practice of Surgery and Clinical Surgery," removed a bullet from the 'sofra arbutal region,' (is this Columbus science, or only a compositor's error?) and that the patient is doing well. The seal of the true scientific spirit is put on this article by the closing statement that "Tucker will completely recover, and that little hole in his head, about the size of a silver quarter, will never bother him a bit."

Thus is shown not only the very advanced state of surgical skill in our capital city, but the high plane of medical ethics. So far as we are told there was not a single homeopathic physician present at the operation. The man who can cure fits of several years' standing, and with certainty predict the result, is a man to be proud of, and we have the word of the Ohio State Journal that the patient has been operated upon and that he will recover. Our surgical heroes have cut into the brain; they have flushed the peritoneum; they have even ligated the aorta; but it was reserved for Dr. R. Harvey Reed to remove a bullet from the inmost recesses of a Negro's frontal bone, and it is probably for this reason that his portrait adorns the newspaper article which tells of his triumph.

## Superfluous Schools

THE competition between the postgraduate schools of the East grows keener every year, this being attested by the attractions and inducements to students blazoned forth in the annual announcements of the schools. So great is their zeal to secure the attention of the physicians desiring more knowledge that they do not hesitate to announce themselves as competing for practice (dispensary and hospital) with the profession at large. As has been pointed out before, however, both here and elsewhere, the postgraduate is its own nemesis and a merciless one. Instead of adding to the practice of the teacher it tends to reduce it by the ability to deal with major cases which is imparted to the students of the polyclinic. Besides this, the teacher gets little or no salary; indeed, in some instances, is required to go into his own pocket to assist in meeting the expenses of the school. So the profession need not worry where one school announces that many of its dispensary cases "represent rare and obscure diseases, being sent by their physicians from a distance."

The medical profession realizes plainly that the average income of physicians would not be so low if there were not so many schools, dispensaries and hospitals giving free treatment to many patients well able to pay. Worse than that, these institutions actually bid for more cases so as to have greater attractions for students. The evil is not in having too much clinical material for our medical students, for they need much, but in scattering the teaching work in too many institutions, thereby multiplying many fold the number of cases needed for instruction, as well as half-educating twice too many physicians.

The time has come when physicians who attempt to float a new medical school will be looked upon as arch-enemies of the profession, and when the closing of a school by one of the various State Boards will be looked upon as a boon to the community. Professional opinion must direct itself as much as may be to the closing of as many as possible of our present super-numerary schools as well as to the prevention of the formation of new ones.

While Cleveland has four schools where two would be amply sufficient, it is a paradise compared to the cities of the west and south. Cincinnati, Louisville, Nashville, Knoxville, Atlanta, Kansas City, St. Louis, Chicago, etc., are a standing disgrace to the profession, with their excessive numbers of schools and their low standard of the majority of them. The State Boards and the profession must work hand in hand to weed out this rank growth.



Our own Board deserves credit for refusing to recognize diplomas from three of Cincinnati's schools. That is an excellent beginning and a good example to other State Boards.

### The Decadence of Homeopathy

THE following extract from an editorial in our esteemed homeopathic contemporary, *The Clinique*, is one of the many signs of the times that indicate the ever-progressing effacement of sect in medicine. The acquisition of modern liberal medical education which is necessary to those homeopathic physicians wishing to become thorough specialists compels their attention to rational therapeutics and then the reform is accomplished, even if the trade name is not changed for a generation. All that is necessary today to wipe out these distinctions in medicine is liberal treatment of the sectarians at the hands of the regular medical profession. Error is combated more successfully by courteous treatment than by brusque opposition.

**SPECIALISM AND HOMEOPATHY.**—At the midsummer meeting of the Clinical Society, Dr. Gurnee Fellows (page 484) did good service in urging the claims of the homeopathic remedy to the attention of the specialist, and what was said is quite applicable in other specialties as in that of the eye and the ear. The infatuation of many of our younger graduates and of some of our under-graduates also, with the surgical technique and the super-scientific bent of the times, leads them away from the just claims of our special therapeutics, and the result is that, when medicines and local applications are needed they fly to the coarse and harmful methods of the old-world clinics. \* \* \* \*

Depend upon it the injury that is being done Homeopathy by some of our specialists is not done by them because they are specialists, but because they are ignorant and indifferent to the claims of the carefully chosen internal remedy which, while it cannot always supersede, may often precede and follow the knife to the advantage of all concerned.—*The Clinique*.

### Receipt for Summer Diarrhea

DR. AXEL HOLST, of Christiania, in the *Centralblatt für Bakteriologie*, gives an account of Knetkåse, one of the national dishes of Norway, with some of its legitimate results. Knetkåse, or kneadcheese, is made by warming sour milk in a kettle, and after it is curdled, separating the curds from the whey by pressing it by hand through linen. It is then thoroughly mixed with salt, and incidentally with perspiration, by hand, and broken up as fine as possible. It is then set away, preferably in an oven in a living-room for a time varying from a few weeks to a few months to

ripen. It is then mixed by hand with caraway seed and is ready to be eaten. Strange as it may seem, this dish is not always effective, but it is easy to believe the author's statement that epidemics of diarrhea often follow in its wake. Watermelons furnish a culture-medium almost as good; it is only necessary to cut one in halves, and place it for a few hours in an ice-box of the usual degree of cleanliness. The result will be very gratifying to anyone who wishes several loose movements of the bowels, not unattended with pain.

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AN interview with a well-known surgeon, which appeared recently in the *Cleveland Press*, contains the following interesting statements:

"The germ most frequently present is called *bacillus colli communis*. This bacillus is present in every person. People in the most rugged health are full of it. The bacilli remains dormant until conditions develop which enable it to develop its destructive properties."

"While they are puss-producing germs, they are much less virulent than many others of the same class. If they were as virulent as some of the puss-producers, very rarely would a person escape with or without an operation."

"What is the veriform appendix, and what are its uses?"

"In some of the lower order of animals it exists," and so forth. The reporter seems to regard the ordinary domestic cat as a bacterial product, a theory which, if proved, will shed much light on the origin of species.

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THE following advertisement appeared in the *Cleveland Leader* of September 15 and other dates:

LADIES—Chichester's English Pennyroyal Pills (Diamond Brand) are the best. Safe; reliable. Take no other. Send 4c. stamps for particulars, "Relief for Ladies," in letter by return mail. At druggists'. Chichester Chemical Company, Philadelphia, Pa. Mention *Leader*.

With its right hand the *Leader* always stands ready to editorially score the abortionist, while with its left hand it slyly receives money for an advertisement whose deliberate purpose is to popularize the same crime—abortion. Practically all newspapers occupy this same inconsistent attitude, but the *Leader* has always been better than the average and probably does not realize the peculiar position in which the acceptance of this advertisement places it.

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PAPER by Dr. G. Arch Stockwell, in the *Scientific American Supplement* of July 18, 1896, calls attention to some facts which the medical profession has been tardy in recognizing. The author points out that cod-liver oil is valuable in wasting diseases because it is, usually, an easily digested fat. But many writers on dietetic and wasting diseases have recognized the fact that butter is more easily digested and more palatable, and

would be more valuable than the oil were it not due to the unfortunate liability of most butters to butyric fermentation, giving rise to serious dyspepsia. This has heretofore prevented a more general use of an excess of butter in this class of cases, because the best dairy is unable to eliminate from the butter all the lactic acid ferment. Besides this, butter, largely through its contained milk, is liable to convey tubercle bacilli or any other pathogenic germs which might get into the milk in the process of manufacture.

Good oleomargarin, which can only be made from the very best qualities of fat, is open to none of these objections. Jollies and Winkler, in the *Zeitschrift fur Hygiene*, have recently shown that the only bacteria to be found in good oleomargarin are those usually found in air and water. In no instance were they able to detect any pathogenic bacteria. Oleomargarin is cheap and convenient and deserves a fair trial at the hands of the profession, the only precaution necessary being to ascertain that the product used comes from a reputable maker.

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NEW YORK'S Commissioners of Charities, after using two wards of Bellevue Hospital for two months for the trial of a secret cure for inebriety, were finally compelled to retreat ignominiously from their position, under pressure of the wrath of righteous citizens and with the added disgrace of the neglect of their own *protege* to do his duty and obey their own rules. At a time when heat prostrations and acute illness were excessive, two wards of this great hospital lay empty, with dozens of suffering human beings clamoring for entrance, and the physician, to test whose secret "drink cure" the Commissioners had set apart these wards, for two successive weeks, did not even once enter the hospital. A fitting end indeed to the most disgraceful episode ever chronicled in the history of the great hospitals of America. To the eternal shame and disgrace of the Commissioners be it added that during all those two weeks, in the face of public calamity and in despite of their sworn duty and of all instincts of humanity, they doggedly refused to let the sick and dying into those wards.

It is almost impossible to believe that men could be so inhuman in the present day. Sympathy is due New York in her disgrace, and great credit is due to the *Medical News* for its fearless exposure of the scandal.

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THE following curious sentence occurs in a review of Dr. James B. Herrick's Handbook of Medical Diagnosis, on page 439 of the September number of the *Post-Graduate*.

"Sense of security" and "albumose," p. 29; "these neral," p. 230; and "arrhythmia," p. 239, and other pages, are evidently typographic offenses, which are more common here than is usual in the excellent productions of Lea.

We are accustomed to look to the East for accuracy in medical writing. What shall we say of the New York critic who never heard of an albumose, and who was too lazy to look up arrhythmia before objecting to its being spelled correctly?

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THE advertisements in a medical journal are a necessary part of its existence and prosperity under present conditions. When scrupulous care is exercised by the editors to keep out objectionable features from the advertising pages, the advertisements are a very useful portion of the journal and deserve attention at the hands of the journal's readers. Many a new and available idea, remedy or device is first presented to the profession through the advertisement of a legitimate business firm.

Extreme care is exercised by this JOURNAL to give its advertising space only to firms of unquestionable integrity and merit, therefore our readers may be sure of always finding something profitable in our advertising pages. By watching them carefully it will be noted that something new is presented each month which will repay well a moment's attention.

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### Our Toledo Letter

THE regular course of lectures to the nurses in Toledo Hospital Training School for Nurses will begin September 20. The School opens this year with a class of 26 students, which is a larger attendance than for any previous year.

The Toledo Medical College has cleared itself of the charges which were brought against it before the Board of Medical Registration and Examination.

The citizens of Toledo are looking forward with fear to the oncoming fall. The cause of this condition is due to the discharge of all the sanitary policemen, due to a depletion of the funds of the Health Board. The sanitary condition of the city is bad. The odors from decomposing garbage, the foul smell of sewer-gas and the uncared-for cesspools produce a great variety of disease-producing germs.

The garbage wagons patrol the city's thoroughfares overloaded with garbage, and sprinkling the streets with the fluid escaping from the wagon boxes. Not only the fluid escapes, but from the overloaded wagons fall melon rinds, corn-husks, rotten apples, tomatoes, etc. Is it any wonder the mortality rate of Toledo has increased, and that typhoid-fever and other contagious and infectious diseases are more prevalent? We hope something may soon be done, so that Toledo can again be able to say that she has the lowest mortality rate of any city in the Union.

## Does It Pay to Take Your Own Journal?

**I**F you desire to know what your neighbors are doing in the practice of medicine, or to have them know what you are doing, it pays to take your home medical journal. If you wish to read articles upon the latest medical subjects, written by those in your own vicinity, and to learn what is being done by those about you with the recent advancements in medicine, you must be pleased with your local medical journal, and will not do without it. If you desire to be informed concerning what the medical societies in your own and neighboring states are doing, you cannot get along without it. Your own journal is the only periodical which has any special interest in local matters, and nowhere else will you find a history of medicine in your own locality. Your local journal has an interest in you, for you belong to the brood that finds warmest welcome under its wings.—*Medical Sentinel*.

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## Twenty-Five Hundred Medical Men in Paris Battling with Starvation

**T**HAT is the number estimated by the Paris correspondent of the *British Medical Journal* who are now struggling with an overwhelming burden of rent and taxes. After fifty years of honorable practice, Dr. Langlard found in suicide his only escape from starvation.

In America, too, much poverty and misery has prevailed among medical men, especially during the distressing period which began in 1893. The panic, the multiplication of gratuitous clinics and dispensaries, the low prices for hospital treatment, and other factors, are cited as the prime and principal causes.

But no one has yet placed the proper emphasis on the baneful and blasting results of one evil for which the doctor may thank himself, and himself alone—the multiplication of proprietary preparations, and the self-medication which must inevitably follow in their train. Every prescription for a proprietary remedy is an admonition to the patient that he is wasting his fee and can dispense with the doctor's services; the quicker the cure the more certain the loss of the patient, the circulation of the prescription among the public, and the free advertising of the remedy for self-treatment.

Medicine has always been an overcrowded profession; it always will be; and the struggle for existence will continue to be severe. But if it remain the arena of a terrible life-and-death combat, in which talent, learning and labor strive in vain for bare existence, the strugglers can only blame themselves for encouraging those conditions which shut out even a forlorn hope of success in the fight.—*Bulletin of Pharmacy*.

## OFFICIAL PROCEEDINGS

OF THE

## Cleveland Medical Society

REGULAR MEETING, September 11, 1896

*The President, DR. COOK, in the chair*

The following new members were elected:

CHAS. MANTEY, Minerva, O., Graduate of Western Reserve, 1885; non-resident member. W. H. SMITH, of Akron, O.; Graduate of Cincinnati College of Medicine and Surgery, 1872, non-resident member. J. C. WILSON, Philadelphia, Pa.; honorary membership.

## Reports of Cases and Exhibition of Specimens

DR. WILLIAM LINCOLN

*Carcinoma of the Nose*

I have a case to report which occurred in my practice, of carcinoma of the nose. In the most recent work on the nose, that of Moritz Smith, he gives among 33,000 cases of nasal disease and disease of the air-tract, including the larynx, only five cases of carcinoma of the nose. He divides these into three classes, true epithelioma being the most frequent, and the next in frequency medullary carcinoma, of which this is an instance. This patient simply complained of the unilateral stoppage of the nose on the right side for the last two months. There had been no glandular involvement and no discomfort from the growth. There was a purulent discharge from that side of the nose, and, on examination, a tumor was found very similar in appearance to an abscess of the septum. It was a smooth mass which pressed very firmly against the septum, although attached to the inferior turbinated bone on the right side. It could be determined that it was not an abscess of the septum by the very simple method of passing in a probe which went between the tumor and the septum fairly freely. The tumor was removed as far as possible under cocain. My brother, Dr. Walter Lincoln, has very kindly made sections of this tumor, which I will pass around. There was a nodular mass in the velum. I think the operation will be of temporary benefit to the patient. The other form of carcinoma which occurs in the nose is of extreme rarity.

DR. R. R. BAILEY

*Fracture of the Humerus*

I think it may be of interest to report a case of fracture of the lower third of the humerus, caused by pitching a ball last Monday. The subject was a muscular man, and when he delivered this ball he fractured the arm. These cases do occur but are rather rare.

DR. W. H. HUMISTON

*Tubal and Ovarian Disease*

I have a specimen here of interest only in so far as it shows the appendages after repeated attacks of inflammation. This woman had her first pelvic attack 12 years ago, but she has had recurring attacks since. At one time, from symptoms elicited, she had suppuration in the pelvis. I show here the specimens that I removed on Tuesday; the ovary degenerated and massed together with the tube. The adhesions were very extensive and firm. The omentum was adherent over the bladder and *fundus uteri*, and the intestines were thoroughly matted together. The operation was a difficult one owing to the extensive and firm adhesions.

She wished to try for a time the conservative treatment, *i. e.*, hot-water douches and rest in bed. The only benefit she derived was a general improvement, and less tenderness in the pelvic organs on pressure. The fixed condition of the uterus and the lateral structures was found practically as it was before the eight weeks of rest in bed and long-continued hot-water douches. We permitted her to get up, and on the slight amount of exertion in walking from the bed to the bath-room the pain recurred. She was then desirous for operation. This was done on Tuesday, and the drainage tube was used for 24 hours. So far she has had an uninterrupted convalescence, highest temperature 99°, pulse 110.

**Program**

DR. D. S. HANSON

*Intestinal Antisepsis in Typhoid Fever*

This paper appears in full on page 468 of this number of the JOURNAL

**Discussion**

DR. W. H. LUCAS: I should like to ask Dr. Hanson if he ever used nitrate of silver. I have used it myself in several cases this summer in doses large enough to prevent the patient's bowels moving more than once in two days. Dr. Pepper orders 25 to 30 grains of nitrate of silver for the purpose of allaying congestion, but not as an antiseptic. I gave about 20 and used sponge baths. In six of my cases in which this treatment was used the temperature never reached 104°.

DR. C. F. DUTTON: I believe we have no better antiseptic today than mercury in some form. It may be proper for us to inquire what is the condition of the alimentary canal needing antiseptics; what poisons are you going to neutralize? I think it is admitted by those who have looked most into the subject that it is the toxin due to the typhoid bacillus and not the bacillus itself. The first we know of typhoid-fever is headache, showing that the nervous system is already affected. Then there is a certain sense of exhaustion. There may or may not be diarrhea. In cases that are severe there is such a condition of toxemia that consciousness is lost. When you are using antiseptic treatment what are you "antisepting?" Are you cleaning the bowels; are you neutralizing the toxin, or are you simply preventing chemically the decomposition of albuminoids? If we find out that antiseptic treatment produces good results we will stick to it just as we do to quinin in ague. I have tried antiseptics and have failed; I have tried a great many other things and failed. I sometimes let my typhoid patients alone so far as treatment is concerned and do better than with medicine. I presume if

I had had more faith in somebody's theory none of my patients would have died. I think it must be a glorious thing for a man to know that he has got hold of something that if taken "in season" will cure that disease which has carried off more than any other disease.

**DR. P. M. FOSHAY:** Dr. Dutton throws down the gauntlet. Men who are doing surgery can have some positive knowledge of means and results, but I doubt if there is a disease which is open to the absolute proof that Dr. Dutton demands for this treatment; and I do not think it is fair to demand of any new treatment that the proof should be perfect when the old treatments were adopted without any such proof. That the antiseptic treatment of typhoid-fever is a valuable treatment I think has been shown by the experience of a great many men, and that it depends upon a rational basis I think all the members of the Society feel convinced. It is true that the administration of antiseptics has by some observers been found not to reduce the number of bacteria in the stools to a great degree, and yet it has been shown that we do reduce certain forms of bacteria very materially. The species that inhabit the large intestine are very hard to kill, while those of the small intestine and stomach are more or less within reach.

Dr. Dutton, for whose opinion I have a great deal of respect, says that the first symptoms of typhoid-fever are those of the absorption of toxins. This is unquestionably so, but it does not invalidate the antiseptic treatment. If fuel is being constantly poured upon a fire that we wish to extinguish, the first rational thing to do is to stop putting on fuel. In typhoid-fever the bacilli are the fuel and the natural eliminative process is barely able to keep up, at best, with the production of fresh toxins. So long as the bacilli live in the intestinal canal so long the toxins are being produced to poison the body. While no one can look into the intestinal canal and see what is being done, clinical evidence seems to show that antiseptics help to curtail the production of toxins.

**DR. G. S. SMITH:** Two years ago I was a medical officer in one of the eastern hospitals where we made experiments. All the patients during a period of six months were given nothing in the way of antiseptics, and those in the following six months were. The hospital reports show no great difference in the mortality records. It was my experience there that the fecal matter as a rule contained none of the typhoid bacilli for the first two weeks. One of the speakers referred to intestinal antiseptics as causing this. I think it is quite possible in a certain number of cases that the examinations were made too early. We know that the multiplication of the bacilli takes place in the spleen and mesenteric glands as well as in Peyer's patches. It is claimed by everybody now that a great many germs will live in quite strong solutions of bichlorid of mercury, 1 to 5000. It seems to me that by the time the antiseptics get so far down as the small intestine they must be so greatly diluted as to considerably hinder their efficacy.

**DR. C. W. WOOLDRIDGE:** We all know that nitrate of silver is instantly decomposed in the presence of chlorid of sodium. I would like to know in what manner the nitrate of silver acts as a local astringent, or whether there is any reason to believe that it acts as nitrate of silver.

**DR. J. T. SMITH,** of Collinwood: In a full report of an epidemic of typhoid-fever in the town of Stamford, Conn., given by a local health officer, one physician had treated 14 cases without giving any medicine at all, except



water, and all of them recovered. Another physician reported very good success with Protonuclein. I think this about equivalent to giving no medicine at all. It seems that without medicine cases sometimes do about as well as with it.

**DR. H. H. POWELL:** Eleven days ago I was called to see a lady who was suffering with severe headache in the frontal region and at the back of the head and neck. Her temperature was  $101.5^{\circ}$  and her tongue was heavily coated. On the next day her temperature was  $101^{\circ}$ , and in the evening she still suffered intensely with the headache. On the third day the temperature was  $98.5^{\circ}$ , and it has been so since. On the fifth day she was taken with delirium and remained delirious for four days, requiring two trained nurses to manage her. On the seventh day there appeared the most abundant eruption that I have seen for a long time on the chest, abdomen, back and limbs. It was so marked that the mother asked if it could not be scarlet fever or measles. The bowels moved twice a day and there was no distention. The pulse was normal after the second day. Today she is rational. I speak of this as an afebrile case of typhoid. Different writers allude to this afebrile type and all speak of it as comparatively rare, except during the Franco-Prussian war. I have tried nitrate of silver in a number of cases with good results, but not as an antiseptic.

**DR. C. J. ALDRICH:** I have observed quite a number of cases of very low temperature in typhoid but with not so free a rash. This leaves in my mind a doubt whether they were typhoid. I had one case of very low temperature in which without any warning the temperature ascended to  $107^{\circ}$ , and from there on to the full register of the thermometer before death.

**DR. HANSON:** The subject of intestinal antiseptics is a very broad one, and the number of toxins developed in the course of the disease is very great. They are some of them taken with food, some caused by the action of the liver. Of course, we cannot expect intestinal antiseptics to reach all these. The greater part of them are retained in the intestines and the more insoluble they are the better they do. It has been shown that toxicity of the urine can be greatly lessened, which shows that most of them may be absorbed. As to the treatment with nitrate of silver, I have never used it and don't know anything about it. I am a gold man.

**DR. C. J. ALDRICH**

*Clinical Cases—Multiple Sclerosis and Focal Epilepsy*

This paper appears in full on page 455 in this number of the JOURNAL

**Discussion**

**DR. H. S. UPSON:** The great interest to me of multiple sclerosis lies in the variability of the symptoms. From the fact that sclerosis occurs in spots and that these spots may be located anywhere in the brain or spinal cord, the symptoms may be as various as the number of cases we have to deal with. I recall one case which I saw several times in consultation, of a man who had lain in bed for four years. He had very severe pains in the back and head which are unusual in this disease. The knee-jerks were increased and he had marked atrophy of some of the muscles of the legs and arms, but absolutely no intention-tremor.

I recall another case seen here in the city, in which the patient, a man of possibly 35 years of age, had no paralytic symptoms, no eye symptoms at all and nothing but a condition which might be described as hysterical.

He would laugh and cry very readily without reason for doing so. The reflexes were only slightly exaggerated. The disease ran its usual course, and on necropsy the brain and spinal cord showed many patches of sclerosis, some of which in the medulla were sufficient to cause death.

DR. G. W. CRILE: There is a surgical feature of the last case which struck me as very interesting. The method advocated and practiced by Victor Horsley and others of exposing a good area of the brain and using the battery to locate the point of the beginning attack might be used in this case. I remember a localization that was made of the thumb center in which the first attempt gave arm movements, but by changing the position of the electrode on the surface of the brain, it was possible to get the action of the thumb. When the point has been localized it is necessary to cut to a considerable depth and generally at right angles to the surface of the convolution.

DR. I. FRIEDMANN: In case number three the doctor spoke of the child having jaundice, due to embolus in the liver. I wish to ask the doctor if this ever produces jaundice.

DR. ALDRICH: It is a well recognized fact, particularly in mitral stenosis, that a small embolism will sometimes produce jaundice when not large enough to give any very serious disturbance, such as abscess or infarction.

Dr. Upson spoke of a very interesting case in which there were symptoms of hysteria. Charcot called attention a few years ago, before disseminated sclerosis was recognized in England, to the fact that a good many of those cases have been diagnosed as hysteria by the Englishmen. His criticism aroused quite a little excitement in medical circles. While in London a few months ago, I heard Dr. Buzzard pay a great tribute to Dr. Charcot, in which he made this statement: that he believed the doctor was perfectly right in saying the English had not recognized this disease, and he knew a great many cases sent out with a diagnosis of hysteria, who had come back to him as cases of multiple sclerosis. One morning he gave a very interesting demonstration of the difference between hysteria and multiple sclerosis, in cases in which there were no tremor and eye symptoms. Were it not that disseminated sclerosis is very liable to affect the pons and medulla, where a spot of almost any size is liable to involve the motor tracts, we would probably have no type of the disease whatever. The demonstration consisted in showing us that in cases of hysteria we have nearly always the same increase of knee-jerk and of the other reflexes, but that none of them show the jaw-jerk, and every one of them was insensible to the tickling of the sole of the foot; there was no plantar reflex. On the other hand, in all the organic cases, there was not only an increase of the muscle-jerks in general, but a very active plantar reflex.

DR. W. H. HUMISTON

*Clinical Case—Pelvic Abscess*

This paper appears in full on page 462 of this number of the JOURNAL

#### Discussion

DR. M. ROSENWASSER: The doctor has failed to state in this case what was the nature of this abscess. Was it visceral abscess or an abscess of the broad ligament? I agree fully that the course pursued was proper. This was one of those septic cases in which dense intestinal adhesions complicate and prolong the operation beyond the safety line. It is better surgery

not to remove the organ involved, but merely to drain and remove later if necessary. The cure cannot be radical. A fistula may remain. The patient, however, gets better, gains strength and is in better condition for the secondary operation. The advocacy of radical operation comes from Dr. Joseph Price, who successfully breaks up adhesions and removes the abscess sac. My own experience has been similar to that of Dr. Humiston. I have had cases which have completely recovered without secondary operation.

DR. G. W. CRILE: If the abscess remained some time and became sterile I can imagine a suprapubic operation might be advisable. On the other hand, if this were an acute infection, and if the abscess were recent and full of bacteria, I can imagine that one might take chances in making the suprapubic operation. I would like to inquire whether the vaginal operation has any advantage over the suprapubic one.

DR. HUMISTON: Answering Dr. Crile, I would state that my practice has been to do the vaginal operation when there is distinct fluctuation through the vagina, as in broad ligament abscesses; but you frequently have an abscess of the tube or ovary that is very difficult to reach through the vagina. You make an incision and perhaps cut into structures that complicate the case. In fact, you are taking too great risks. I think there is a limited field for the vaginal operation.

I always like to feel the fluctuating mass readily by palpation. The first case, with 110 ounces of pus, had such a condition, that is a fluctuating mass could be felt in the vagina. It was opened and drained, and about four ounces of pus drawn off. This was dressed and kept in good condition by a competent physician. She had a cyst of the ovary, quite a large cyst, perhaps the size of a cocoanut. She got better and commenced to sit up when she was taken with chilly sensations and fever, and the contents of the tumor became septic and took on a rapid growth until after a few weeks it reached above the umbilicus. Her kidneys gave evidence of being involved.

I chose, after carefully considering the case, to attack the abscess through an abdominal incision as being less dangerous than from the vagina. The vaginal incision would have been a deep one and the chances for opening the intestine great. I believe these cases can be done much more safely from above. You can see what you are doing and can protect the immediate structures from contamination by the free use of sterilized gauze. If the adhesions are extensive and firm, I believe it is better to get thorough drainage, with a minimum amount of tearing apart of adhesions, and let the patient recover from her low condition, when, if necessary, as Dr. Rosenwasser has said, do the secondary operation.

This last case in which the abscess communicated with the intestine was so virulent that if a drop of the pus had entered the general peritoneal cavity there would have been serious trouble. The odor was so intense that it made all who witnessed the operation uncomfortable.

## A Joint Meeting

Of the Union Medical Association of Columbiana and adjoining Counties, the Union Medical Association of Northeastern Ohio, and the Eastern Ohio Medical Association, held at Alliance, Thursday, September 17, 1896

DR. J. H. TRESSEL of Alliance, President of the Eastern Ohio Medical Association, and DR. HENRY S. UPSON of Cleveland, President of the Union Medical Association of Northeastern Ohio, in the chair.

DR. A. C. YENGLING of Salem, read a paper on "Friedreich's Disease" and presented a case. The disease attacked several members of the same family, coming on as a rule between the ages of five and ten years. The intellect was impaired, the gait quite ataxic and the reflexes exaggerated in the patient whom he showed.

DR. A. B. WALKER of Canton, read an essay on "The Importance of Making Examinations of the Sigmoid Flexure." This paper appears on page 464 of this JOURNAL.

### Discussion

DR. MOORE of New Lisbon, said that impactions are most frequently overlooked. A young lady, some years ago in his practice, while still unmarried had attacks of pains in the bowels. She was afterwards married and had a child. The attacks continued, but ceased after washing out large masses of fecal matter from the bowel. Another case occurred to him of a gentleman from Pittsburg, who had been treated by several physicians for a long while for intestinal pain and vomiting. Examination showed dullness of the left half of the abdomen. The dullness and symptoms disappeared after the washing out of the rectum and colon.

DR. HUMISTON made it of late years a routine practice to examine not only the rectum but the sigmoid flexure. He said that a long speculum or endoscope gave a good view of the sigmoid.

DR. BATES of Alliance, had a case some years ago with whom he worked half a day to remove an impaction larger than a goose-egg. The impaction contained grape-skins and mucus. No grapes had been eaten for two months. He had suffered for a month before the removal of the impaction.

DR. WALKER in closing, said that the Wales rectum douche was easily used. It may be attached to a Davidson syringe. No pain is caused by it and there is no need of an antiseptic.

DR. HUMISTON read a volunteer paper on "Cases of Pelvic Abscess and a Method of Treatment." This paper appears in full in this number of the JOURNAL.

DR. J. A. ROACH, of Alliance, read a paper on "Summer Remedies," in which he gave a thorough resumé of the bismuth compounds and some of the newer antiseptics used in the treatment of bowel trouble, with the results attained by them in his hands.

DR. C. F. HOOVER, of Cleveland, delivered a lecture on "The Study of the Pulse." He spoke especially of the change which the pulse undergoes in arterio-sclerosis. He mentioned a case of a woman of middle age who had

suffered for several years from very severe pains in both feet. Anti-neuralgics had entirely failed to give her relief. He found on examination all the vessels healthy except the *dorsalis pedis* arteries in both feet, which were markedly sclerosed. The pain ceased entirely on the administration of moderate doses of nitro-glycerin.

DR. H. H. JACOBS, of Akron, reported a case of enlarged prostate in which he had had considerable difficulty in drawing off the residual urine with a catheter.

DR. MOORE, of New Lisbon, has never had any difficulty in drawing off the urine if he could introduce a catheter, and he did not see what constituted the difficulty in this case.

DR. A. A. ELLIOT read a paper on "Spinal Irritation," and reported a case. His patient fell from an oil-derrick, a distance of 32 feet, and was found lying on his back. He was taken to a railroad station, taken 35 miles on the train and then seen by a physician. He was first seen by Dr. Elliot on July 26. He was free from pain, his pulse 84, and his temperature normal. There was a deformity in the lumbar region of the spine. He had a large bed-sore; there was complete paralysis below the deformity as well of the bladder and the rectum as of the lower limbs. The penis was in a semi-erect condition. The knee-jerks and plantar reflexes were absent; the epigastric, abdominal and cremasteric reflexes were present. The treatment was directed to the healing of the bed-sore.

DR. N. S. SCOTT of Cleveland, said that the question in this case was whether there was fracture with pressure or fracture without pressure, but with concussion. If the symptoms are not much better within a week after the injury there is probably compression; and an operation should be performed at once. If there is much destruction of the cord nothing can be accomplished. Good results have been reported from operations as late as two years after the injury. It is very difficult in this case to decide whether an operation would benefit the patient or not. The most efficient way of healing bed-sores is by a water bed. The bed-sore should be healed before an operation is attempted.

DR. BALLINGER of Alliance, said that a child twelve years old was some years ago playing along the street. A man seized her by the back and playfully held her over his head with her feet and head hanging down. She was at once unable to stand and had partial paralysis of the lower limbs and numbness of the plantar surfaces. Suspension and a plaster jacket were used in treatment. She developed abscesses in the locality of the injury and bits of necrosed bone have been removed three times from the last dorsal and first lumbar vertebrae.

DR. ELLIOT said, in closing, that this bed-sore appeared four years after the injury, and was not, in his opinion, due to pressure. He did not think a water-bed would do much good.

The Clinical Committee, Dr. Santee, Dr. Hoover and Dr. Blankenhorn, reported a case referred to them. The patient, a young lady of 14, began to menstruate at 11. She had had for fourteen months diarrhea, alternating with constipation. Her maternal grandmother died of consumption. She herself presented no evidence of tuberculosis. She had fever nearly all the time, and at first had a temperature of  $99\frac{1}{2}^{\circ}$ . In the opinion of the Committee there was a simple colitis which should be treated by large injections.

DR. J. H. TRESSEL of Alliance, read a paper on "Painful or Sensitive Stump after Amputation." He spoke in the main of the pathogenesis of the affection and is making experiments in the treatment which he hopes to report later. In one case which he saw the nerve had been properly severed. The artery was, however, entirely occluded back for an inch and a half. There was sleeplessness. The amputation had been performed at the shoulder-joint. It was very difficult to ligate farther back. In cutting off the artery an inch and a quarter back no blood flowed; then a quarter of an inch back of that, and still no blood. In cutting a quarter of an inch farther back a little blood began to flow. The patient has been well ever since the removal of this occluded artery.

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### Ammonol in the Courts

The President of the New York Board of Pharmacy's Connection with a Proprietary Remedy

A MOTION was argued in the Supreme Court before Justice Pryor, August 21, in an action brought by Dr. Cyrus Edson, late of the Health Department, against the Ammonol Chemical Company, of New Jersey, and Dr. Allen H. Still and F. W. Stemmler, in which he asks that Still and Stemmler be enjoined from making or further selling a preparation made by the company, and for the abrogation of a number of contracts that he made with the two defendants, charging that they have defrauded him out of an interest in the company, and have failed to carry out their contracts.

It appears that in 1892, he, with Still and Stemmler, the former a physician and the latter a commission merchant, entered into a contract, under the terms of which a stock company was to be formed for the manufacture of Ammonol and its sale to physicians. Stemmler was to furnish capital and push the sales. Still was to boom it among physicians, and Edson was to furnish the formula, and also to use his influence to have the preparation adopted. Stemmler got 60 percent, Still 20 percent, and Edson 20 percent of the stock.

As stated by Edson's lawyer, Dr. Ullo, Dr. Edson, through motives of "professional delicacy," did not care to hold stock or figure openly in the scheme, so he agreed to surrender his 20 percent of stock for a one-tenth interest in the dividends of the company. He now contends that it is this interest out of which he has been defrauded by the conspiracy of the defendants, Still and Stemmler, who, he says, to further their conspiracy, have voted to themselves salaries of \$3,000 and \$2,000 a year respectively, and have tampered with the books and papers of the corporation.

Dr. Pincoffs, representing the defendant, Stemmler, referred sarcastically to Dr. Edson's "professional delicacy." Justice Pryor was plainer. He said:

"The whole amount of the matter is that Dr. Edson was willing to take his profits from a quack medicine."

"Oh, no, your honor," cut in Dr. Pincoffs; "it is not a patent medicine; it is a very good thing."

"Well, at any rate," said the Court, "he was willing to appear indifferent to the sale of the preparation, while he was really talking it up to the profession for his tenth interest.—*American Druggist and Pharmaceutical Record.*

## Medical News

**Dr. J. Perrier** has returned from a three months' trip abroad.

**Dr. O. B. Campbell** was in Chicago the first week in September.

**Weir's Index** to the Medical Press has suspended publication.

**Dr. John M. Ingersoll** has returned from his summer trip to Vienna.

**Dr. Wm. H. Humiston** returned early in September from his summer vacation.

**Dr. C. A. Hamann** visited his parents in Iowa the first two weeks in September.

**Dr. Edwin E. Sheffield**, of Elyria, was married September 15 to Miss Millie Halter.

**Dr. and Mrs. C. B. Parker** took advantage of the Mississippi Valley excursion to Yellowstone Park.

**Dr. H. J. Herrick, Jr.**, was married September 9 at Mt. Forest, Canada, to Miss Henrietta Letitia Wilks.

**Dr. E. G. Carpenter** has established a permanent office on the fourteenth floor of the New England Building.

**A typhoid-fever** epidemic of great severity has been afflicting the little oil town of Gibsonburg near Fremont..

**Dr. H. J. Lee's** brother-in-law, Mr. Frederic W. Ayer, died at his residence, 71 Tilden Avenue, September 8.

**Dr. Coyt H. Beight** of the class of 1896 at Starling Medical College, has removed from East Palestine to Petersburg.

**Dr. Charles F. Hoover** spent the early part of September in Washington doing work in the Surgeon-General's library.

**Dr. J. F. Madden** of Elyria, president of the free-silver club of that town, was in the city August 31 to hear Mr. Bryan.

**Dr. Montgomery Linville** of New Castle, Pa., was in the city August 31, having come to hear the speech of Mr. W. J. Bryan.

**Dr. Carlos C. Booth** of Youngstown, is the inventor of an excellent motor for horseless carriages, which is attracting much attention.

**An epidemic** of diphtheria is prevailing at Niles. The schools were closed September 14 in order to aid if possible in checking its spread.

**Dr. P. F. Beverly** of Columbus, an ex-president of the Ohio State Medical Society, died September 18 of paralysis at the age of 69 years.

**Dr. L. B. Tuckerman** has been prominently mentioned as candidate for Congress in this (twenty-first) district on the combined Populist-Democratic ticket.

**A new medical college,** The Metropolitan Medical College, has just been incorporated in Chicago by G. W. Alson, Lewis N. Curott and Edward F. Millard.

**The railroads** to Mexico are offering great inducements to physicians desiring to attend the Pan-American Medical Congress in November. The rates are very low.

**A case** of subcutaneous emphysema is reported by the newspapers to have occurred at Somers, Wis., by a boy falling on stubble, some of which penetrated to the lungs.

**Dr. Charles Goodman,** a graduate of Western Reserve Medical College in 1892 and now senior resident surgeon in Mt. Sinai Hospital, New York, visited friends in the city early in September.

**Despite the** pressure which was brought to bear the Ohio State Board of Registration and Examination has finally refused to recognize diplomas from the Hygeia Medical College of Cincinnati.

**The newspapers** of September 11 announced that the State Board would begin prosecutions against illegal practitioners as soon as their attorney, ex-Attorney-General J. K. Richards, returned from New York.

**Dr. William H. Smith** of Akron, Dr. Gustave Shane of Waynesburg, and Dr. Byron Chapman of Copley, a graduate from Western Reserve University in the class of 1847, were among those in attendance at the Cleveland Medical Society, September 25.

**Dr. Edward H. Pratt** of Chicago, of orificial surgery fame, has been sued for \$25,000 damages by a lady upon whom he did the "American operation" for epilepsy. She avers that she will never recover from the effects of the operation.

**Reducing the Death Rate.**—The death rate in Chicago is going to be materially reduced, not by the introduction of needed sanitary measures but by estimating the population of the city at a much higher figure than heretofore.—*Medical Record.*

**Up to September 22** only 520 physicians of Cuyahoga County had registered their certificates with the Probate Court, although Cleveland alone has a list of 700 and over. Everyone now practising without registration is liable to summary arrest and fine.

**On October 16** the Massachusetts General Hospital will celebrate the fiftieth anniversary of the discovery of ether as an anesthetic. The celebration will be also accompanied by the exercises attendant upon the opening of the new pathologic laboratory.

**The Cleveland College** of Physicians and Surgeons opened its first session under the new name Wednesday, September 16. Professor Edward T. Nelson, of the college department of Ohio Wesleyan University, made the



opening address. The outlook for the school this year is better than ever before.

**St. Louis is the** proud possessor of two hospitals, each owned by a stock company and run for the profits in the business. People are solicited to become members by paying fifty cents a week, for which, in case of sickness, they receive hospital care. This is the lowest stage yet reached by the hospital abuse.

**Dr. William Thomas Corlett**, after attending the International Dermatological Congress in London, went to Paris and then to Aix-la-Chapelle (now Aachen) for a short stay to personally inspect the hot springs at that famous resort. He sailed from Hamburg, September 24, on the Augusta Victoria, and will arrive home October 1.

**Dr. W. R. Bricker** of Shelby, a graduate of Western Reserve University in 1857, died suddenly at his home on September 7. He was a non-resident member of the Cleveland Medical Society, whose meetings he attended as regularly as possible, as he was a warm friend of the Society. He was one of the three oldest members of the Ohio State Medical Society.

**Among** the prize-winners of the Palisade Manufacturing Company's contest for \$600 in prizes for essays upon "The Clinical Value of Antiseptics," the following Ohio physicians appear: Dr. D. S. Maddox, Marion, fifth prize, \$25; Dr. Charles A. Hough, Lebanon, one of the five \$10 prizes. The first prize of \$250 went to Dr. E. P. Bailey of Yardley, Pa.

**An interesting** news item comes from Lorain. Dr. O. M. Stephenson, who had secured a certificate from the State Board of Medical Registration and Examination but had failed to file it in Probate Court, sued a delinquent client for professional services. On motion of the defendant's attorney the case was dismissed because the physician was not registered according to law.

**There is talk** of closing the public schools of Chicago because the Board of Education has not provided filters for the school buildings. The recent heavy rains have contaminated the lake out as far as the crib, and typhoid, scarlet fever and diphtheria are seriously prevalent. The grand jury is investigating charges of criminal neglect against the Board of Education.

**Late one evening** a doctor received a note from a couple of fellow-practicians, saying: "Pray, step across to the club. We are one short for a game of poker."

"Emily, dear," he said to his wife, "I am called away again. It appears to be a very serious case, for there are already two doctors in attendance."—*American Druggist*.

**Dr. John B. Hamilton** of the Marine Hospital Service, and also editor of the *Journal of the American Medical Association*, has been ordered by the

chief of the M. H. S. to proceed to the station at San Francisco. He has, however, appealed to Secretary Carlisle for an annulment of the order, on the ground that when he first went to Chicago he was promised a permanent stay there of eight years.

**The opening exercises** of the medical department of Western Reserve University were held September 23. The address of the occasion was delivered by Dr. Hunter H. Powell. The exercises were attended by 120 students, and the indications point to a large number of students, which is remarkable because of the depressed commercial situation and because four-years' study is required of the class now entering.

**Dr. A. C. Bernays**, Frank Ruff and the Antikamnia Chemical Company have been sued for \$60,000 damages by Anita May George, who was operated upon for stricture of the esophogus by Dr. Bernays. The patient's pictures before and after operation, together with a history of the case, were printed in a pamphlet (150,000 copies alleged) advertising Antikamnia. Damages are asked because of the publicity given the plaintiff.

**The Ophthalmic Record**, published and edited at Nashville by Dr. G. C. Savage, is about to cease its existence unless 700 subscribers at \$3.00 a year are at once secured. In the event that they are, the *Record* will be moved to Chicago and placed under new editorial and business management. In his farewell editorial Dr. Savage pleads the increasing burden of his practice, college work and other duties as necessitating the change.

**As a result** of the growing popularity of the highlands of southern New York and northern Pennsylvania as resorts for consumptives, the town of Liberty, in Sullivan County, N. Y., has just passed an ordinance, according to the *New York Herald*, forbidding, under penalty, all persons from expectorating upon the sidewalks, dooryards, or floors of houses. The Health Board does not wish the little town to become a center of infection.

**The homeopathic** brethren are using Koch's tuberculin in 12x and 30x strengths, put up in tablet form, for the cure of acute lobular pneumonia. The *rationale (sic)* of the treatment is founded upon Virchow's reports of necropsies of persons dying of tuberculosis after the administration of tuberculin. Virchow reported finding catarrhal inflammation of the lobules of the lung, and so tuberculin is found to be a very powerful remedy for lobular pneumonia!

**On the Occasion** recently of the retirement of the house physician of the City Hospital, Dr. D. E. Hoover, a farewell reception was tendered him by the hospital employees. Among those present were Mr. and Mrs. William Hanna, Mr. and Mrs. Thomas Pennington, Mrs. E. C. Hawkins, Dr. J. S. Kennedy of Kent, Dr. A. F. Spurney, Dr. C. A. Hamann, Dr. H. Wagner, Dr. G. Frost, Dr. L. W. Childs, Dr. S. L. Bernstein, Dr. H. Haskins, Dr. J. C. Steuer, Dr. W. O. Osborn and Dr. Charles Tanner.

**Legal Measures Threatened** —It seems that the Harvard Evening Medical College and Hospital, of Chicago, has, without authority, announced Professor Edwin Klebs, M. D., as occupying one of its chairs. Professor Klebs has warned it that unless the catalogues containing this announcement are suppressed, he will institute legal proceedings. It is against the same college that Harvard University was recently seeking an injunction to prevent the use of the name Harvard.—*Medical News*.

**The Ohio State Board** of Medical Registration and Examination has found, among other unpleasant things, according to the *Lancet-Clinic*, that certain medical colleges in the State have been accepting matriculation tickets from other schools as evidence of attendance at courses of lectures. Also diplomas have been granted upon this basis, the recipients perhaps never having heard a lecture. A college which poses as reputable has been doing this. In justice to the profession it ought to be exposed.

**THE CLEVELAND JOURNAL OF MEDICINE** has removed to its new and commodious quarters, Nos. 512-515 New England Building, 129-131 Euclid Avenue. The proprietors of the JOURNAL are wide-awake business managers, and publish to the profession a periodical which is in many respects unique and in every way well adapted to the up-to-date medical practitioner. We congratulate the JOURNAL upon its well-deserved success, and hope to see its prosperity continue.—*Journal of Medicine and Science*.

**The annual meeting** of the Association of Erie Railway Surgeons was held at Jamestown, N. Y., September 21. The meeting was a large and interesting one. The election of officers for the ensuing year resulted as follows: President, Dr. Webb J. Kelly, Galion, Ohio; Vice-President, Dr. F. W. Thomas, Marion, Ohio; Secretary-Treasurer, Dr. W. W. Appley, Coshocton, N. Y.; Executive Committee, Dr. C. M. Daniels, Buffalo, N. Y., C. S. Parke, Hornellsville, N. Y., and Dr. E. H. Leyman, Huntington, Ind.

**Water Supply of Cleveland, Ohio.**—This water supply is drawn through an intake constructed at the expense of several million dollars—a tunnel extending under the bed of the lake a distance of 8,642 feet to the crib. Theoretically, the currents render the water about the crib safe, but storms and counter-currents running eastward often force polluted water into the pipes. The water has been degenerating steadily. The city has concluded to make a large expenditure to lengthen the tunnel, purify the water, and erect a garbage crematory.—*Medical News*.

**The typhoid-fever** epidemic at Indianapolis continues to assume larger proportions and quarantine measures are being taken to prevent an epidemic. The typhoid scourge which recently prevailed in Utica, New York, was traced to its source in the city wells and the measures taken by the Board of Health to avoid further infection have been successful. The epidemic at Cambridge, Mass., had its origin in a dairy that employed a boy of fifteen,

a convalescent typhoid patient, who was engaged in washing and filling family distribution cans.—*Maryland Medical Journal*.

**Dr. T. W. McCue** of Akron, began a suit for \$50,000 damages in the Cleveland courts last Saturday against the Clark-Otis Chemical Company. He claims that the company, by underhand methods, obtained possession of a secret formula for an antiseptic which he is manufacturing. He also claims that since the company have gained possession of the formula they have commenced to manufacture the article on a large scale and are successfully placing it on the market. Dr. McCue asks that the company be enjoined from manufacturing the article until the suit shall be decided.—*American Druggist and Pharmaceutical Record*.

**The American Humane Association** met in this city September 21 to 25. The meeting was well attended. A sweeping resolution against vivisection and endorsing the bill recently before Congress to suppress vivisection in the District of Columbia was adopted. Dr. G. W. Crile and Dr. L. B. Tuckerman spoke for moderation but found no supporters. At the succeeding session the same gentlemen tried to secure a reconsideration of the vote on the resolution in order that its wording might be made more moderate, to the extent of favoring vivisection under proper and rigid restrictions, but the Association would not even listen to the proposition and the matter was dropped.

Great credit is due Dr. Crile, who, as a member of the Humane Association, was finally able to secure the taking of action by which the committee appointed to push the anti-vivisection bill before Congress is instructed to confer with a committee to be appointed by the American Medical Association with a view to agreeing upon a compromise bill which will be acceptable to physicians. This action is of the utmost importance to the profession of the whole country, and they can thank physicians of Cleveland for securing this concession.

**The Doctor's Bicycle.**—Every city has municipal laws which prohibit the riding of bicycles upon the side-walks; and demand that the rider proceed at a reasonable speed along the main thoroughfares. These laws, as a rule, are very exacting, and not infrequently physicians, in their haste to reach patients are obliged to violate the common ordinance and oftentimes are obliged to pay fines in common with the rider who is out for pleasure pure and simple. Such laws are wrong, for frequently, should the physician go at the speed and in a manner in accordance with the ordinance, a life would be endangered and possibly sacrificed. We believe that physicians are entitled to more than ordinary consideration in the matter of bicycle riding in all cities, and have no doubt that the authorities, if the subject was presented in a proper manner, would grant them the desired protection. In conclusion, we would like to insist that the matter be taken hold of generally

by the profession, and whenever possible supported by both the medical and public press.—*New York State Medical Reporter*.

**Easy Fishing.**—Some of our exchanges for July are still calling the attention of their fellow-publishers and editorial sojourners to the utter worthlessness of any bills which they may have against the Thompson Laboratory Company, of Washington, D. C. They had better remain quiet over such matters. This company sent out orders for full page advertisements, and some journals were so ready to take anything which came along in the advertising line that not a single inquiry was made concerning the financial standing of the company or the value of the products advertised. The advertisement itself was enough to keep it out of good journalism, while an inquiry would have satisfied the publishers on the financial question. Talk about trout jumping at a fly! It is not a circumstance to the way some publishers grab a hook baited with an ad.—*The National Medical Review*.

**In the matter** of attendance the recent meeting of the Mississippi Valley Medical Association was somewhat of a disappointment to its promoters, only about 140 physicians being in attendance. The fact that the American Public Health Association at Buffalo and the Missouri Valley Medical Association at Council Bluffs were in session at the same time contributed greatly to the reduction in attendance. Dr. Thomas Hunt Stucky, of Louisville, was elected president; Dr. C. A. Wheaton, of St. Paul, vice-president; Dr. Paul Paquin of St. Louis, second vice-president; and Dr. H. W. Loeb, of St. Louis, was re-elected secretary. The next meeting will be held at Louisville, in October, 1897. The following Ohio physicians were registered as in attendance: Dr. J. S. Beck, Dayton; Dr. E. Hawn, Leetonia; Dr. J. H. Buckley, Cincinnati; Dr. E. M. Houghton (?), Dr. A. F. House, Dr. J. F. Hobson, and Dr. X. C. Scott, Cleveland; Dr. F. F. Lawrence, Columbus; Dr. G. I. Cullen and Dr. J. H. Buckner, Cincinnati; and Dr. J. R. Peipes (?) Crestline. (The interrogation points indicate names which do not appear in any of the directories and which probably belong to gentlemen in some other part of the country, their appearance here being probably due to an error in transcribing the list).

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### PROMPT ACTION NECESSARY

The Doctor—Mrs. Brown has sent for me to go and see her boy, and I must go at once.

His wife—What is the matter with the boy?

The Doctor—I don't know; but Mrs. Brown has a book "On What to Do Before the Doctor Comes," and I must hurry up before she does it.  
—*Puck*.

# Condensed Table of Mortality in Cleveland for August, 1896

By courtesy of Dr. J. L. Hess, Health Officer

## I.—FEVERS.

Influenza.....	0
Typhoid.....	15
Scarlet fever.....	1
Measles.....	0
Diphtheria.....	10
Varicella.....	0
Intermittent fever.....	1
Cerebro-spinal.....	1
Erysipelas.....	0
	28

## II.—DISEASES OF THE NERVOUS SYSTEM.

Marasmus.....	9
Meningitis.....	13
Softening of brain.....	1
Abcess of brain.....	1
Apoplexy.....	3
Epilepsy.....	0
Tumor of brain.....	0
Sclerosis of brain.....	0
Hydrocephalus.....	1
Aneurism of brain.....	1
Tetanus.....	3
Anemia of brain.....	2
Cerebral embolism.....	1
Myelitis.....	1
Dentition.....	0
Convulsions.....	30
	67

## III.—DISEASES OF RESPIRATORY SYSTEM.

Croup.....	2
Croup—membranous.....	0
Bronchitis.....	10
Phthisis.....	20
Pneumonia.....	22
Pleurisy.....	0
Congestion of the lungs.....	5
Edema of the lungs.....	0
Gangrene of the lungs.....	1
Tuberculosis.....	15
Cancer.....	2
Empyema.....	1
Asthma.....	1
Emphysema.....	1
Whooping cough.....	1
	81

## IV.—DISEASES OF THE DIGESTIVE SYSTEM.

Perforation of intestines.....	2
Strangulated hernia.....	0
Gallstone.....	0
Gastritis.....	4
Gastric ulcer.....	0
Cancer of liver.....	0
Cancer of stomach.....	6
Enteritis.....	4
Peritonitis.....	6
Appendicitis.....	0
Obstruction of intestines.....	1
Diarrhea.....	7
Dysentery.....	3
Cholera Infantum.....	60
Enterocolitis.....	18

Cholera morbus.....	2
Jaundice.....	0
Hepatitis.....	0
Acute yellow atrophy.....	0
Abcess of liver.....	2
Cirrhosis of liver.....	3
	115

## V.—DISEASES OF CIRCULATORY SYSTEM.

Dilatation of heart.....	1
Fatty degeneration of heart.....	1
Rupture of heart.....	0
Pericarditis.....	1
Endocarditis.....	19
Myocarditis.....	4
Valvular disease.....	9
Aneurism.....	2
Fibroids.....	2
Anemia.....	1
Pernicious anemia.....	1
Pyemia.....	0
Septicemia.....	4
Puerperal fever.....	1
Rheumatism.....	3
Rickets.....	0
Syphilis.....	1
	50

## VI.—URINARY DISEASES.

Nephritis.....	10
Acute Bright's disease.....	0
Chronic Bright's disease.....	0
Cystitis.....	0
Diabetes.....	0
	10

## VII.—GENERATIVE SYSTEM.

Postpartum hemorrhage.....	0
Cancer of breast.....	0
Cancer of uterus.....	0
Puerperal eclampsia.....	0
	0

## VIII.—VIOLENT CAUSES.

Accident.....	15
Suicide by hanging.....	0
Suicide by shooting.....	0
Suicide by poisoning.....	2
Suicide by drowning.....	1
Homicide.....	2
Asphyxia by overlying.....	0
Burns or scalds.....	2
Railroad injuries.....	1
Shock.....	1
	24

## IX.—UNCLASSIFIED.

Inanition.....	19
Premature birth.....	3
Senile debility.....	26
Alcoholism.....	1
Sunstroke.....	1
	50

Total deaths for August, 428. Total deaths for August, 1895, 475.

Annual death-rate per 1000 during the month (estimated population 330,279) 13.26+

**The British Medical Journal** urges that antipyrin be classed as a poison and that pharmacists should only be allowed to dispense it under the usual laws regulating the sale of poisons. The numerous deaths from its use by self-medicators furnish sufficient justification for the plea.

**Wisconsin** is engaged in the meritorious work of stamping out the many fake colleges which have recently flourished within its borders. The Attorney-General of the State has brought *quo warranto* proceedings against the Wisconsin Electrical Medical College, the Wisconsin College of Dentistry and the Milwaukee University. The evidence shows all three to be most flagrant frauds.

**The newspapers** report the successful use of the Roentgen rays in locating a needle in the knee of Dr. J. W. Prendergast, health officer of Cincinnati, rendering easy its subsequent removal.

**That modern** sanitary precautions are effective has no better proof than in the remarkable experience of the Anglo-Egyptian army, now so far up the Nile. Deaths from cholera are fewer among the invading unacclimated troops than among their opponents, the native Dervishes. Prompt measures of isolation and disinfection instituted by Dr. Gallwey, the surgeon-in-charge, have prevented the spread of the disease in a situation where, of course, quarantine is impossible, and have so far been effective in preventing an epidemic. The soldiers are forbidden to drink of the infected Nile water, the command being enforced by flogging and threatening death. Modern medical science boasts of a great triumph in meeting the deadly cholera in its favorite haunts and utterly defying it. The contrasted decimation of Spanish troops in Cuba speaks ill for the efficiency of their medical corps.

**Mr. Lewis C. Hopp**, the well-known pharmacist of this city, has been elected chairman of the Commercial Section of the American Pharmaceutical Association. The *American Druggist* celebrates the event by publishing a half-tone portrait of him, together with a short biography, which shows that he has taken a leading part in all efforts for the advancement of pharmacy, especially in this State, for the last 10 or 15 years.

**From** *The Nation* we learn that during the past summer semester 2,192 foreign students have attended German universities, of whom 1,665 were Europeans and 527 from other continents. Of the latter number nearly all (442) were Americans. Of the whole number 488, or more than 25 percent, studied medicine.

**The medical colleges** of Missouri are having a lively time, which is, however, not altogether a novel experience. The State Board of Health has ordered that all prospective medical students must first pass an examination to determine if they come up to the required standard of general education. The Barnes Medical College has employed legal talent to fight the ruling of the Board and has asked the other colleges of the State to join with it. The Beaumont Medical College makes good use of the opportunity by refusing to join in the movement for the good reason that medical students ought to pass such an examination.

# Cleveland Journal of Medicine

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NOVEMBER, 1896

No. 11

## Diagnosis of Typhoid Fever

BY W. C. CHAPMAN, M. D., OF TOLEDO

I SHALL offer no apology to this Association for the title of my paper. It would seem that we, as practitioners, with some years of experience and observation in the treatment of fevers, especially those of continued type, should be able to accurately diagnose them so that no mistake be made either in prognosis or treatment. And yet I am certain recently many mistakes have been made, not only causing undue anxiety to immediate relatives of the patient, but great loss to the community in which the case of supposed communicable disease has been observed. There are three or four diseases which strike terror to any neighborhood, markedly diphtheria, smallpox and typhoid fever, and the responsibility resting upon the physician is a grave one. The card tacked upon the residence by a health officer in any of our cities, quarantines the resident family effectually and the neighborhood is shunned by all. A mistake made in diagnosis works irretrievable wrong to the community, and is a pecuniary loss difficult of computation.

Not many months since, in the city of Toledo, it was said that in a neighborhood many cases of typhoid fever had originated from infected milk derived from a certain dairy. It was stated that a number of the dairyman's family had been suffering from that dread disease, and through the milk it had been conveyed to families supplied from that source. From one to another the story circulated and the innocent dairyman lost most of his customers. Complaints were made to the health officer and a thorough examination made both of the milk and the premises. The looked-for

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*Read before the Tri-State Medical Association, Angola, Ind., July, 1896*



bacteria were not found; the dairy was said to be unusually clean, and all the cows in a healthy condition. The local authorities, with a determination to confirm or overthrow the findings of the city chemist, sent specimens of the milk and the water used in the dairy to the microscopists and bacteriologists of Ann Arbor, who returned a report that both were absolutely pure. In face of all these scientific reports the business of the dairyman was for the time ruined, entailing upon him great pecuniary loss.

It was my fortune to attend quite a number of cases of the prevalent disease in the supposed infected neighborhood, and at no time did I find a case that I diagnosed typhoid fever. All cases ran a long course of fever of the adynamic type, but with few of the so-called pathognomonic symptoms of genuine enteric fever. One case, remarkable in many of its manifestations, died, but was not considered typhoid fever, although the patient was in bed many days, dying, as I believe, from exhaustion. Another case seen for some days with my friend, Dr. Tracy, unexpectedly died when convalescence seemed established, not, as I believe, from perforation, but from the formation of heart-clot. Seeing a number of such cases of continued fever during the fall and winter just passed I was induced to make as thorough a study of them as possible, endeavoring to determine whether we were really having an endemic of typhoid fever in Toledo or whether another pathologic condition was being considered and named for the infrequent disease true typhoid or enteric fever. I was not able to search for the supposed specific germ either in the blood or discharges, either of bladder or bowel. My opinion is given without such confirmatory proof from close study of the symptoms and signs through the whole course of the disease. In Toledo typhoid fever is not common. Whether its development is prevented by superior drainage or from unusual care of personal surroundings, I am not prepared to say, but I am certain from my experience and from my intercourse with fellow practitioners that Toledo is free to a marked degree from this dreaded disease.

I have selected two cases to bring before you today which are to me typical of exceedingly dangerous forms of disease, and which I believe may be easily mistaken the one for the other unless observed with great care and studied in detail. The differentiation is all the more necessary because of the treatment which must be instituted that the best results be obtained.

It was my fortune to attend two nearly typical cases of the diseases of which I write—Miss M., in December, a case of "grip," with marked abdominal manifestations, and Mrs. T., during March and April, a genuine case of typhoid fever with nearly every diagnostic symptom. I present them to you briefly with the accompanying charts, which, to me, without further history, show a marked difference in disease manifestations.

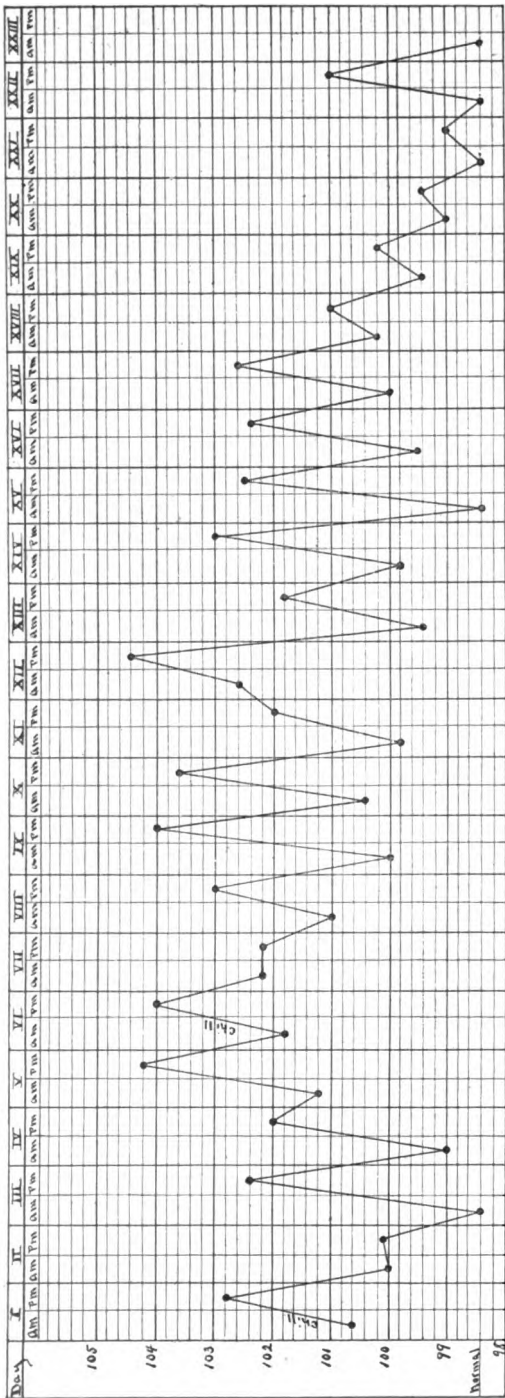
It will be noticed that the history of the cases begins with the first day of observation and runs through twenty-three days before convalescence was established. After the time thus given in both cases there were daily changes of temperature, slight, however, until a week more had passed, when the normal temperature was reached permanently.

For several days in both cases there had been noticed a gradual decline of bodily vigor, with mental depression more marked in the typhoid case. The clinical history begins when both patients were put to bed. On my first visit to Miss M. she was suffering with severe headache and nausea, depressed and feeling very ill, complaining of pain and soreness over the whole body, especially in the dorsal and cervical region. The face was flushed and the expression one of anxiety. The tongue was slightly furred, the pulse was 98 and temperature a little over 100°. On my first visit to Mrs. T., I found her with a slightly reddened tongue and some nausea, suffering with an intense frontal headache, but complaining of no other pain. The countenance was dull in expression but the face slightly heightened in color. The temperature was 101°, pulse 120, bowels normal or rather constipated.

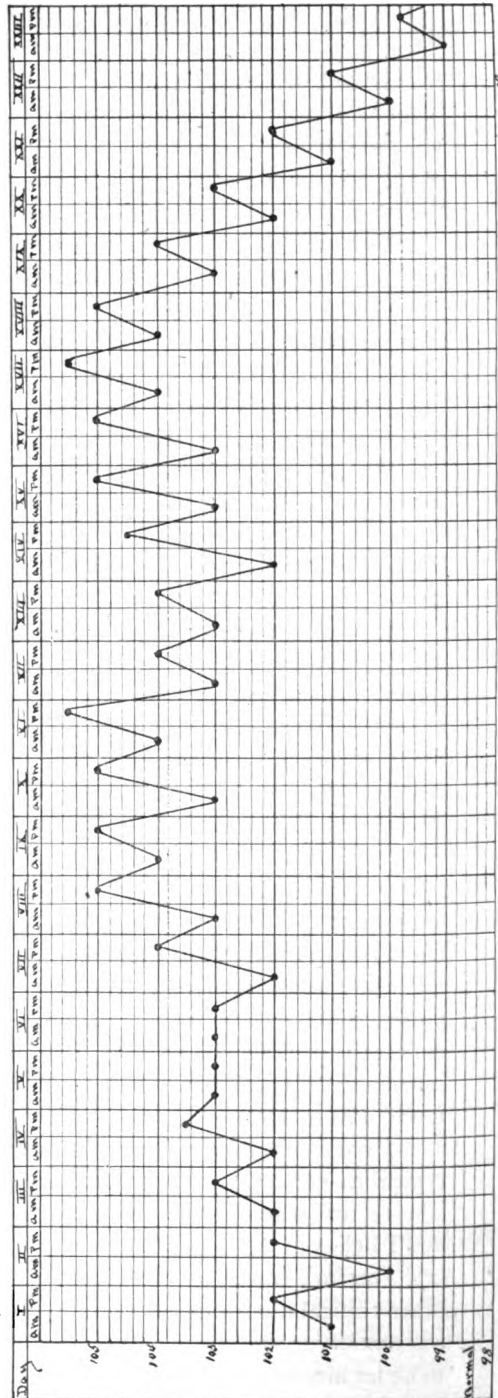
It was apparent to me that I was observing two cases of fever and what form they might take time alone would show. By constant observation through the whole sickness I was able to arrive at satisfactory conclusions as to the nature of the maladies, and experience with other cases in my own practice and in consultation with other physicians has led me to believe that we often make mistakes in confusing cases of *la grippe* with marked intestinal complications and typhoid or enteric fevers. There is one difference to which I will refer that has been a constant condition in a majority of my cases of grip, and that is the lack of the expected relation of pulse to temperature. We are taught that for every 1° rise of temperature we will find a rise of ten beats of the pulse; only twice in the case of grip I am reporting, the variation of temperature of which is shown in the chart, did the pulse go above 100, 104 being the highest number counted, showing to me conclusively that the poison of grip must be a great nervous depressant, especially to the heart. Not so, however, with the typhoid fever; here I found 120 to 130 pulsations per minute to be the rule.

I have prepared a chart showing the variations of temperature in my typical cases; to me it indicates a wonderful difference in the fever markings. The record was made carefully, both morning and evening at the bedside, and I believe it to be correct.

Having, therefore, made my diagnosis, I will briefly endeavor to show other clinical manifestations that will, I hope, prove satisfactory. In grip there was anxiety, restlessness and slight delirium. In typhoid, depression, a desire to be let alone and afterward active delirium and hallucinations. In grip no nose-bleed or hemorrhage after stools; in typhoid abdominal tenderness,



Typical Case Graph 1.



Typical Case Graph 2.

tympanites with much distention of bowels. In grip constipation persistent; in typhoid, some dejections and during second and third week diarrhea with ocher-colored discharges and gurgling in the right iliac fossa. Anorexia persistent in both diseases. Headache was severe in typhoid, but general pain in back, head and limbs marked in grip. In both diseases the tongue was coated, more markedly in typhoid, with some sordes on the teeth, but by great attention by the nurse, the mouth was kept fairly clean. There were many lenticular-colored spots in the typhoid case; none in the other.

It is, I believe, necessary that a true diagnosis be made as soon as possible, so that proper treatment may be instituted, as the desired results cannot be obtained unless well-selected remedies are employed. It was positively necessary that the bowels in case of grip should be unloaded by free catharsis and kept at all times open. For this reason Rochelle salts, calomel, castor oil and enemas were used with turpentine stupes constantly applied to the abdomen. Phenacetin and salol were used to allay muscular pain and even morphin hypodermically was used on several occasions, so severe were the muscular pains and soreness. Soups and milk were constantly given with strychnin and quinin for tonic effect.

In the typhoid case, for the first time in my practice, I employed the "Woodbridge treatment," beginning with the "number two" tablets and keeping them up day and night for two weeks. A faithful nurse administered the medicine. The administration of four grains of quinin at bedtime was the only other medication, with the exception of liberal use of Port wine and *Vin Mariani*, which were especially agreeable to the patient; milk, sometimes with an egg, was her nourishment, until convalescence was established.

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## Some Observations of Malarial Organisms in Close Connection with Typhoid Fever

BY JOHN P. SAWYER, M. D., CLEVELAND

*Professor of the Theory and Practice of Medicine in the Western Reserve Medical School*

IN 1888, in an article on the geographic distribution of typhoid-fever in the United States, read before the Association of American Physicians, Dr.

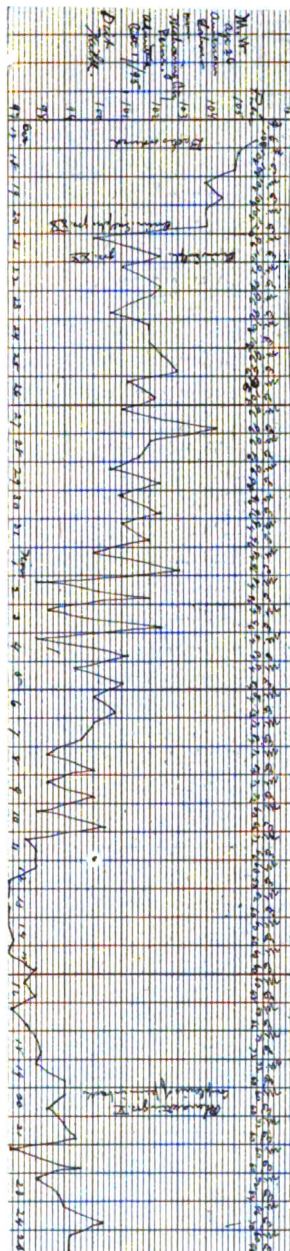
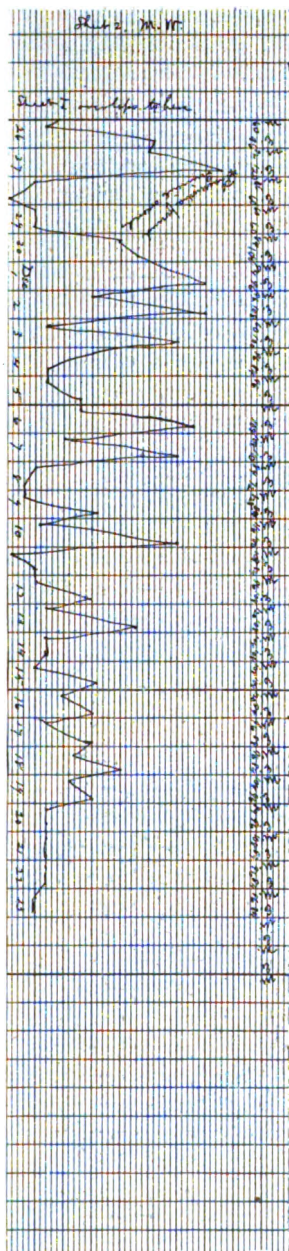
W. W. Johnston, of Washington, sums up very forcibly the opinion of representative men of the profession in a large part of the country, and states that as then employed "the term typhomalarial-fever has no determined meaning, leads to confusion and misunderstanding, is a cover for uncertainty and ignorance, and should be discouraged and abandoned." At that time of course there had been no chance for professional opinion to be formed, based upon the recognition of the malarial parasite and the typhoid bacillus. Dr. Johnston ascertained that "the number who believe that typhoid-fever is modified

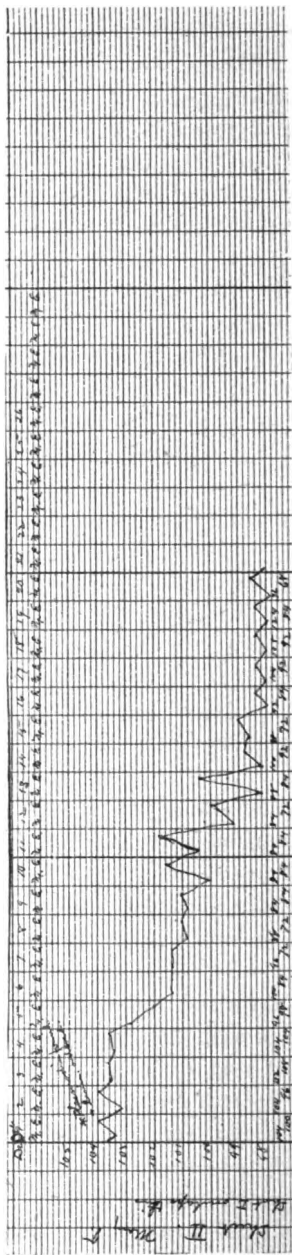
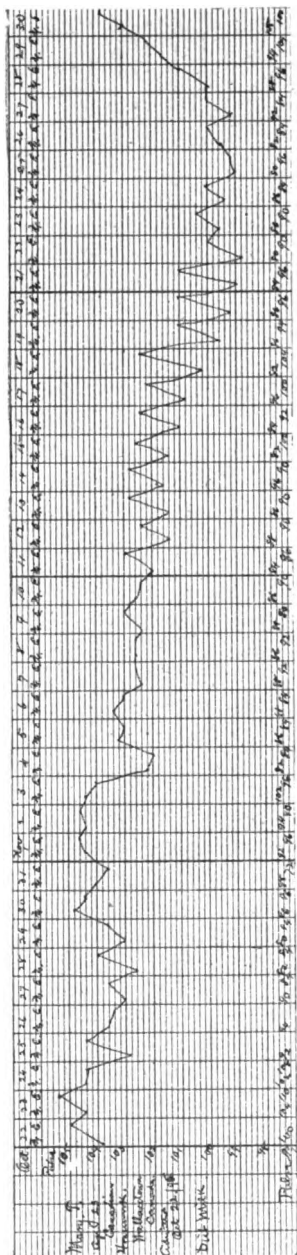
by malarial infection is nearly equaled by those who are sure there is no such combination—that the two diseases never unite their symptoms in one individual.” Were it true that there is such a combination commonly found, we might reasonably expect by this time to have had a considerable number of positive observations. This, however, is not the case. On the contrary, in *The Johns Hopkins Hospital Reports* in 1894, Osler, on the basis of a material of about 500 cases of malarial-fever and 229 of typhoid, writes, “There was no case with the characters of the two diseases so blended that it seemed a compound or hybrid malady, nor was there an instance in which the manifestations of the two diseases were concurrent.” He mentions three cases with a definite history of malaria within a few months. In each case, however, the malarial history preceded by weeks or months the development of typhoid-fever. A fourth case admitted with malaria, as shown by the examination of blood, was treated with quinin, and for six days the temperature was entirely normal. Then came a rapid rise of temperature which at first was thought to be malarial, but the case pursued a “perfectly normal course of typhoid-fever, typical but of great severity.”

In the *American Journal of Medical Sciences*, August, 1894, W. Gilman Thompson, of New York, reports three cases of typhoid-fever, in the first of which abundant malarial organisms were found in the third and fourth weeks of a protracted case, clinically recognized as typhoid in view of the “distinct eruption, epistaxis, intestinal hemorrhages, and tympanites, in connection with all the other symptoms.” Two other cases are presented in which abundant malarial organisms and pigment of the blood-corpuscles are reported five and eleven days respectively after the temperature of a typhoid had reached normal.

These are the only cases which I have been able to find in which malarial organisms were recognized in close connection with the typhoid-fever. In none of these cases were typhoid bacilli recognized, nor in the cases which I have to present was any attempt made to determine their presence. With the aid of the procedure recently suggested by Elsner, this would be a more simple and certain matter than has been heretofore possible.

Case I.—N. W., age 25, a laborer from Pennsylvania, was admitted to the Charity Hospital October 17. He has always been well. He feels very hot, has had a chill this morning, no vomiting, no headache, no pain in limbs. There is a markedly coated tongue, the papillæ swollen, with a thick brown fur, red-edged; the conjunctivæ slightly icteric. There has been a slight constipation, there are present some tympany, some tenderness over the right iliac region, slight gurgling on pressure; there is a noticeable enlargement of the spleen, the temperature is 103.8°, pulse 108, dicrotic. Examination of the heart and lungs indicates only a slight bronchial catarrh, corresponding with which the patient has a slight cough. The diazo-reaction is very pronounced. This evening the temperature rose to 105.8°. Cold baths were







promptly ordered, and while their effect in the reduction of temperature was obtained it did not persist, and the temperature almost continuously ranged above  $104^{\circ}$  until the 20th, when the condition of the nervous system seemed to be so unfavorably affected by the persistent high temperature and the pulse seemed to be growing weaker, that quinin was ordered, twenty grains at night. There was a prompt fall of temperature to  $100^{\circ}$ , rising only to  $102.4^{\circ}$  at evening. A second dose was given, and thereafter the temperature continued to present the typical appearance of a mild case of typhoid, as exhibited in the accompanying chart. The urine in the second week became albuminous, with granular casts. On the twenty-fourth day the temperature reached normal and remained at normal or below for eight days, when, in the evening, it began to rise slightly until the 26th of November, when it rose to  $102.2^{\circ}$ ; on the 27th rising to  $104.6^{\circ}$ . An examination of the blood showed malarial plasmodia in great numbers. The segmentation of the parasites could be observed, their escape into the plasma, and their entrance and invasion into other corpuscles. It is very unfortunate that the blood was not examined when the patient first came in, but the clinical picture of typhoid was so complete that the possibility of malarial infection also was not entertained. The normal course of the typhoid-fever was passed through, and in the period of convalescence the characteristic phenomena of malarial infection made their appearance and persisted stubbornly. In this connection it is interesting to note the diminished resistance of the patient after the typhoid-fever, as an apparent factor in explaining the persistence of the malarial invasion.

Case II.—Mary T., age 23, Canadian, admitted to Charity Hospital October 22. Two days before this she went to bed sick, having felt badly for a week, complaining of intense headache and backache. She was seen by Dr. J. E. Cook and sent to the hospital as a typhoid case. On admittance her tongue was moist, coated with a thick fur, brown posteriorly, tremulous; there was a slight gurgling in the right iliac region, slight tympany, enlarged spleen, isolated roseola spots, heart normal, slight catarrhal rales in the lung, and the diazo-reaction. Her temperature on admittance was  $103.8^{\circ}$ , rising to  $105^{\circ}$  that evening, and in spite of the free use of baths sometimes as low as  $64^{\circ}$  F. the temperature persisted, with development of stupor and acceleration of heart-beat. Quinin was ordered in 20 and 30 grain doses for each night through the succeeding week in connection with the baths. The temperature ranged between  $103^{\circ}$  and  $104.8^{\circ}$ ; then sinking to lower levels it assumed the typical appearance of a mild typhoid case, as is seen in the accompanying charts. After a course of five weeks, while running between  $99^{\circ}$  and  $100^{\circ}$ , it on the 28th of November began to rise steadily through a period of three days, ranging at  $104^{\circ}$  and  $103.5^{\circ}$  for four days, when it slowly and steadily sank without typical remissions through the succeeding week,



gradually in the third week of the new development falling to normal. During this time the examination of the blood on the 2d of December showed the intracellular form of the malarial parasite; the pigment bodies within the corpuscles being seen with great distinctness. Segmentation and extracellular forms were not seen.

It is noticeable that the general phenomena during this period of malarial invasion were not those of a relapse of the typhoid-fever. There was little or no tympanites, no diarrheas, no eruption of spots, but it is worth observing that from the 28th of November to the 16th of December, nineteen days were consumed before the temperature became normal. The malarial invasion, which was recognized in this case, occurred before the temperature indicated by its return to normal the cessation of the typhoid process. It occupied a period of time such as is commonly seen in a relapse. The character of the temperature curve of this period is not in its earlier days that of a typical typhoid-fever, but in its last week it approaches closely to the typical last week of typhoid. The same relative characteristics are seen in the early and late portions of the chart of the primary attack. The finding of the malarial parasite in the second period of the fever, and the close resemblance, on a lesser scale to be sure, to the high temperature maintained during the primary attack, render our regrets all the greater that the blood was not examined in the first few days before quinin was freely given, and the course of the temperature approached more nearly the typical typhoid character. That this case was one of typhoid-fever there can be no reasonable doubt, or else we have no grounds on which to trust our diagnosis on clinical observation. But in this case the patient had just arrived in Cleveland from Wallacetown, Canada, where she had been for three weeks while a typhoid epidemic was prevailing, her father dying from the fever, and another case sick in the house. This history gives additional credence to the diagnosis of typhoid, if it be needed.

In neither case could the patient give any history of preceding malarial seizure.

This second case particularly may, I think, be fairly called typhoid with malaria concurrent. Intercurrent might better describe the relations between the typhoid and malarial elements in all these cases. They furnish reason for emphasizing the interest and the advantage of blood examinations early in the course of every case of suspected typhoid-fever.

Clinically, the advantage gained by the exhibition of quinin in this case was very marked—the chart necessarily failing to express all the evidences of improvement which seemed to follow its use. And in cases where the malarial parasite can be recognized, or where there is clear history of previous malarial infection, they fairly suggest the advantage of giving quinin to control high temperature if it exists in such cases.

*122 Euclid Avenue*

## Three Interesting Cases of Abdominal Section with Technic of Operation

BY DR. A. F. HOUSE, CLEVELAND

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OWING to lack of time it has been quite impossible for me to prepare the paper I am scheduled to read tonight, but instead I will report three cases, that I think will be of interest to the Society, together with my method of preparing the patient and the technic of operation.

In all possible cases, the patient is sent to the hospital at least four days before operation. On entering the hospital the patient is given a thorough physical examination, if this has not been done before. All the urine for 24 hours is collected and examined, both chemically and microscopically. General and sponge baths are given on alternating nights, so that the night before the operation the patient shall receive a general bath, together with a vaginal douche of two gallons of a solution of bichlorid of mercury 1-4000. All patients, age not contraindicating, are given sulphate of strychnin grains 1-30, four times a day, from the time of entering up to the time of operation. During the 24 hours preceding the operation the patient is put upon a diet of milk porridge. This is made by boiling for an hour equal parts of milk and water, thickened with flour, to which salt, instead of sugar, has been added. It has been found that this diet does not distend the intestines with flatus. Frequent draughts of water are taken the day before operation, as this has a tendency to diminish the distressing thirst following the operation. When meat is desired, lamb-rib chop, just cooked through, answers very well, as it is more easily digested than any other meat, except the breast of fowl.

During the preparatory treatment it is very necessary that a healthy action of the bowels be obtained every day. The night before the operation the patient is given a dose of calomel and soda, followed in the morning by an enema to insure a free movement of the bowels. Without this preparatory treatment the operation is often rendered more difficult of execution, and the ultimate success more uncertain. It is of importance, also, that the patient have, as near as possible, undisturbed rest on the night preceding the operation and to relieve anxiety by assurances as to the favorable outcome of the case. In the morning of the day of the operation the abdomen is covered with a thin layer of German green soap, and a fresh brush wet

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with water sufficient to form a thick lather is applied vigorously for some minutes; in short, a thorough scrubbing is given, after which a towel dipped in a solution of mercuric chlorid is bound on the abdomen and allowed to remain until the patient is anesthetized. After the patient is thoroughly under the anesthetic, this same cleansing process is gone through again, substituting alcohol and ether for bichlorid.

All tears or abrasions of the pelvic floor are covered with peritoneum and sutured with tendon suture or catgut, thereby dispensing, in many cases, with the use of the Mikulicz tampon or drainage tube. As regards the suture to be employed in closing the incision, surgeons differ; personally, I prefer the through and through suture, although where there are special indications I suture the peritoneum, fascia and skin separately. I use both silk and silkworm gut, and have no reason to complain of either. When silk is used it is boiled for 30 minutes before the operation. The silkworm gut is kept in alcohol, and before using is immersed in a warm solution of bichlorid of mercury 1-1000, which renders it pliable and aseptic as well. The wound is dusted liberally with a powder composed of boric acid seven parts, iodoform one part. This is preferred to pure iodoform as it does not cause an eczema, which, in some cases in which iodoform has been used alone, has been quite annoying. The wound is then covered with gauze that has been kept in a solution of bichlorid of mercury 1-1000; over this a pad of sterilized cotton is placed and this again covered with bichlorid gauze. This dressing may be kept in place by straps of adhesive plaster and an abdominal bandage, and should not be removed until the eighth day, when the stitches are removed, unless there is some special indication.

The after-treatment of all cases of abdominal section, as a rule, is much the same, no matter what may have been the condition for which the operation was performed. The bowels should be moved on the third day, or sooner, if indicated by temperature and tympanites. I prefer salines, followed by an enema, if necessary.

**CASE I.**—Pelvic Abscess of Puerperal Origin. Mrs. O., aged 33, married six years, has had three children, no miscarriages. Her menstruation has always been regular and painless. She has always enjoyed the best of health up to the time of her last labor. On January 16, 1896, she was delivered by a midwife of a healthy child. Her labor was a rapid and easy one, but was followed on the second day by a severe chill, rise in temperature and great pain in the lower abdomen. She experienced great pain during micturition, and it was for this that she called in a physician at various times. A diagnosis of tumor of the bladder was made, but no relief was obtained. Shortly after this the case fell into the hands of Dr. Ralph Wenner, who, upon examination, found a large mass in the right iliac fossa, extending well over to the left of the median line and fixing the uterus firmly in the pelvis. She was then having chills and fever, vomiting, profuse sweats and was very

weak; in fact, her condition pointed clearly to one of sepsis, yet under treatment she improved so much that an operation was suggested to her as her only relief. I saw her in consultation with Dr. Wenner, March 10, 1895, when an examination revealed a mass in the right iliac fossa, extending over the anterior *fornix vaginae*. The uterus, while slightly mobile, seemed to be fixed posteriorly, the culdesac of Douglass being entirely obliterated. No extreme tenderness could be found anywhere. She was sent to St. Clair Street Hospital, but had such a horror of hospitals in general that I advised her husband to remove her to her home until she was still farther improved. This was done, and by June 5 her general condition was much improved and she had gained considerably in strength, although she still had the sweats and paroxysms of fever. She was again sent to the hospital, her husband being given to understand that her case was anything but a favorable one and that the only hope lay in the possibility of the removal of the cause, of which I had grave doubts. After the usual preparation the operation was performed on the morning of June 8. An incision was made in the median line, but revealed nothing save a mass of intestine firmly adherent to and covering the entire anterior surface of the uterus. In order to ascertain just what we had to deal with it was necessary to enlarge the incision, after which the coils of adherent intestine were removed from the anterior aspect of the uterus, showing it to be at least double its normal size and that there was still a large mass above the fundus. I at once made up my mind that there was pus in some part of this mass, and accordingly packed iodoform gauze and sterilized tampons on all sides. Removal of several coils of intestine opened the pus sac, the walls of which were formed below, above and anteriorly by small intestine, the right wall by the *caput coli*, posteriorly by the pelvic floor, the left wall by small intestine and a mass of exudate. A survey of the field made it quite plain that I was in a "rough sea and far from shore," for the anterior and inferior walls of this sac, being formed by small intestine, firmly cemented together, there was no way of breaking it up without perforating or tearing an intestine. I at once took a sterilized gauze tampon, dipped in 1-1000 bichlorid and squeezed dry, and began sopping out the pus. After getting out all possible I filled this space with iodoform gauze, which was allowed to remain until all the abdominal stitches were introduced. I then removed the gauze and introduced a Mikulicz tampon. (The abdominal wound was now closed up to the Mikulicz tampon, which was allowed to remain 48 hours; there being no oozing at this time, it was removed, and the remaining stitches tied). She rallied nicely from the operation and made an uninterrupted recovery. Four months after the operation a small fistulous opening remained. Since that time I have not seen her, so I take it for granted that it has closed.

CASE II.—Miss D., American, age 19 years. Menstruation, which was

regular and moderate, appeared at the age of 14. She always enjoyed good health up to within six weeks of my seeing her, which was August 1, 1893. The history was given to me as follows: Six weeks previously she began to menstruate quite profusely and this continued until she was almost exsanguinated. All this time she had been under the care of a physician, who had used all the agents usually given to check uterine hemorrhage. On making an examination, which was done with difficulty on account of an intact hymen, nothing of an unusual nature was found, with the exception of a slightly enlarged uterus. The treatment consisted in firmly packing the vagina with sterilized gauze, dipped in a saturated solution of alum. The endometrium was mopped out every three days with Churchill's tincture of iodine, or *Tr. Ferri Chloridi*. The constitutional treatment consisted of iron, quinin, strychnin and arsenic. This line of treatment was continued without great improvement up to August 23, '93, when she was sent to the hospital, the uterus dilated and curetted. From this time on the hemorrhage ceased; her menstrual periods were regular as regards both time and quantity, until the fore part of January, '94, when the old condition returned. She entered the hospital on January 30, when the uterus was curetted for the second time. This again had the desired effect until May 1st, when she began having a very fetid sanguinous discharge. Upon bimanual examination an enlarged uterus was found, together with a small mass, seemingly triangular in shape, in the right iliac fossa; the ovaries were enlarged and somewhat tender. Local treatment had no perceptible effect in lessening the discharge or in decreasing the size of the mass in the right iliac fossa. On June 28 a third curetment was done, and some of the scrapings sent to an experienced microscopist, who sent me a note, saying that he had examined the specimen rather hurriedly, but felt satisfied that it was a case of carcinoma of the uterus. On the strength of this I decided to make a hysterectomy. The consent of those directly interested having been obtained, the patient was prepared for the operation. On July 7 Dr. M. Stamm, of Fremont, assisting me in the presence of Drs. McGain, of Elyria, J. L. Hess, Ralph J. Wenner and the house staff, I made the usual median incision. After a thorough inspection and manipulation of the uterus and mass, Dr. Stamm remarked that, owing to its position and hardness, it appeared to be a foreign body in the right ureter. The ovaries were not markedly cystic. After due deliberation I decided to spare the uterus and remove the degenerated ovaries. The patient made an uneventful recovery, and three months after this operation no trace of this mass could be found. As to the nature of the mass, possibly some member of the Society can throw some light. The patient has enjoyed the best of health since the operation, except at the time when she would menstruate, had the ovaries not been removed, during which time she has "hot flashes" and headache.

CASE III.—On May 10, 1896, I received a telegram from Dr. Harry L. Wenner, of Tiffin, Ohio, to come at once prepared to perform a laparotomy. I first saw the patient at 1 A. M., May 11, 1896, and obtained the following history: She had had trouble in the right side for two years, during which time she had suffered four attacks of peritonitis. She was in constant pain and this made life a burden to her. At this time she was just recovering from an acute attack of peritonitis, with temperature 101.4° and pulse 98. Bimanual examination revealed a mass, round and hard, in the right iliac fossa, extending upward and to the left. Early in the morning, assisted by Dr. Ralph Wenner, Dr. Harry Wenner giving the anesthetic, in the presence of Drs. Russell, Dickey, McCallum and Focht, of Tiffin, and Thornberg, of Bloomville, I made an ample median incision, down to the peritoneum, which was firmly adherent to the parietes and very much thickened. Upon opening the peritoneum about two quarts of fluid from an encysted dropsy came away. Enlarging the incision we found a large irregular-shaped mass extending obliquely from the site of the spleen to the right iliac fossa. After separating great numbers of adhesions it became apparent that a portion of this mass was formed by an enlarged dislocated spleen. With great difficulty the spleen was separated from its lower attachments, which proved to be a large oval mass embedded in the right iliac fossa, bounded on the left by the uterus, on the right and below by the ilium and above the cecum. The vermiform appendix was firmly adhered to the top of the tumor and was separated with difficulty. The tumor was peeled out of the cavity like the inside of an orange from its covering. The hemorrhage was somewhat profuse until the cavity was packed with gauze. After removing the gauze the abdominal cavity was flushed with hot sterilized water and mopped dry, removing all blood clots and shreds of tissue. She made a good recovery and is at present doing her own housework. The mass proved to be a large dermoid cyst of the right ovary and was shown to the Society in May.

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### Notes on Laryngitis

BY HOWARD S. STRAIGHT, A. M., M. D., CLEVELAND

THERE is practically one disease of the larynx, *i. e.*, inflammation. This inflammation is most often a simple catarrhal one. Until recent years the important role played by nose and nasopharynx, in other words, the parts of the upper air-passages above the larynx, as etiologic factors in the production of inflammation of the larynx, was not properly appreciated. It is possible that the modern tendency to look to a correction of

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the diseased conditions in the parts of the respiratory tract above the larynx as an all-important means of treatment of a laryngeal inflammation is being overdone. If such be the fact it is an error in the right direction, it seems to me. The larynx and its diseases were studied years before any special attention was given to rhinology. As late as ten years ago, when studying in the throat clinics in Vienna, in all of the more prominent clinics but one the tendency was to make everything throat to the neglect of the nose, at least.

It was only after long study of cases and extensive reading on my return that I came to appreciate properly the importance of looking beyond the larynx in the treatment of laryngeal inflammation, *i. e.*, above it. The mucous membrane of the larynx is delicate and the air must be warmed and moistened by passing through the respiratory passages above. If, because of any abnormal condition of these parts the air reaches the larynx either insufficiently warmed or moistened, theoretically, an irritation or inflammation of the mucous membrane of the larynx is sure to result. While this condition often happens, I am constantly surprised at the number of cases of pronounced nasal or nasopharyngeal or pharyngeal disease or a combination of all of them in which no complaint of the larynx is made. Such cases do not disprove the rule. They are, however, impossible of explanation. About three-fourths of the cases of laryngitis in which well-marked abnormal conditions of the respiratory passages above the larynx exist receive permanent benefit from treatment limited to these parts without giving any special attention to the larynx itself. A very much larger percentage of the cases receive permanent benefit from the nasal, nasopharyngeal or pharyngeal treatment. Even in the cases in which, after waiting one or two years to decide absolutely as to the amount of benefit to the larynx from the treatment of the upper air-passages, and in which the patient has decided that the throat is no better, they almost invariably give a favorable report as to the benefit to the nose, nasopharynx or pharynx. Of course, this statement is made only in reference to the conditions of the upper air-passages that are amenable to treatment. The possible abnormal conditions of the air-tract above the larynx vary somewhat with the age of the patient. Laryngitis in children is comparatively rare, and yet, while I may see more cases of this kind than the general practitioner, and thereby may become biased, I have come to regard laryngitis in children as of more frequent occurrence than one would be led to suppose from the literature on the subject. Many children with a slight laryngitis have little cough and little hoarseness. With reason the condition is regarded as one of little importance by the family or family physician.

This opinion may be correct in so far as the present condition of the child may be concerned. The significance of the slight hoarseness or slight

hacking cough lies in what the laryngeal condition of the child may be at twenty-five or fifty years of age. There is practically one condition that is responsible for the diseases of the ear and upper air-passages in childhood, *i. e.*, adenoid growths and enlarged tonsils. If the faucial tonsils are even moderately enlarged almost invariably adenoid growths are also present. Too often an undue importance is attached to the condition of the faucial tonsil, and adenoids are entirely overlooked. Of the two conditions it seems to me that the enlargement of the pharyngeal tonsil is the one of much greater importance and whose removal promises most relief to the patient. In making this statement I am not losing sight of the fact of the very great relief to many a little patient from removal of the faucial tonsils only, but I am seeking to emphasize the much greater relief that the patient might receive if the complete operation were made.

The classical symptoms of adenoid growths—mouth-breathing, marked deafness and the adenoid facies—are well understood by the profession. When these symptoms occur the diagnosis is readily made, but the fact that a very large number of cases exists in which only slight symptoms occur has not been sufficiently impressed upon the profession. With the removal of the adenoids and faucial tonsils, if enlarged, the slight catarrh of the upper air-passage ordinarily disappears promptly. Children do not have hypertrophic rhinitis even if adenoids are present. Such children as they become older have also a hypertrophic rhinitis if the adenoids are neglected, and I am not certain but this condition occurs later in life even in children whose adenoids were removed. The peculiar diathesis that in a child predisposes to enlarged tonsils and adenoid growths also predisposes the patient to a hypertrophic rhinitis later in life and in women often to a hypertrophy of the lingual tonsil as well. In adults the abnormal conditions of the upper air-passages that may predispose to an inflammation of the larynx are more numerous. As a rule there is an association of abnormal conditions. Too often the throat specialist attaches too great importance to some one abnormal state. There are four conditions most often met with in adults, *i. e.*, hypertrophic rhinitis, deviations of the septum, adenoid growths and enlarged tonsils.

Strange as it may seem, the larynx is most often healthy in cases of mucous polyps. In many marked cases of atrophic rhinitis the laryngeal mucous membrane appears to be little affected by the nasal condition. Of this fact I can offer no reasonable explanation. Occasionally some one of the four conditions is the only explanation of laryngeal inflammation. More often two of the four conditions are present. I have recently had a patient, a young woman aged twenty years, who presented herself with complaint as to her singing voice, who had in a marked degree the four conditions named plus an enormous hypertrophy of the lingual tonsil. Adenoid growths are



commonly supposed to disappear about puberty. Such disappearance very often does not occur. A very large proportion of patients who suffer from diseases of the ear and upper air-passages from fourteen to thirty-five years of age have unatrophied adenoids. I have recently had two cases of adenoid growths, one in a woman aged thirty-six years, the other in a man aged forty-one years. I have, however, seen very few cases over thirty years of age.

Even in the cases in which the growths have disappeared the mucous membrane of the nasopharynx often shows chronic inflammation, and, as far as a radical cure is concerned, a hopeless state of affairs. What the condition of the mucous membrane of the nasopharynx will be in those cases in which adenoids were removed earlier in life is a question which my short experience does not justify me in attempting to answer.

In an acute laryngitis the most marked early symptom is hoarseness and the most marked late symptom is cough. It is easy to understand why the hoarseness occurs in view of the swelling and relaxation of the mucous membrane, but why the irritability of the mucous membrane should be so much greater later in the disease I cannot satisfactorily explain. One would think that exactly the opposite state of affairs would occur, *viz.*: that the cough would start early and decrease with the subsidence of the inflammation.

In many cases the element of cough is not added to the list of laryngeal symptoms. It is a common observation that many a patient, after suffering two or three weeks from hoarseness without consulting a physician, presents himself on account of the cough. An examination of the larynx often reveals only a slight inflammation, but the complaint of the cough may be very great. The treatment in such a case is plain, *i. e.*, an application of a weak solution of nitrate of silver and possible small doses of codein to control the cough; however, there is no way of determining whether the cough will subside on one application of nitrate of silver or whether it will persist after a dozen daily applications. My constant instruction to my patients is "If the cough ceases and the discomfort passes away do not come back. All we want is to relieve your symptoms. I know no way of predicting whether one application will relieve you or whether the condition may not persist for days or weeks in spite of treatment." The appearance of the larynx in an inflammation of its mucous membrane may be useful in deciding as to the necessity for local treatment. A careful inquiry as to the function of the larynx is a more reliable indication for treatment.

Often while the inflammation seems too slight to need local treatment an application of nitrate of silver at once relieves marked cough. One often sees in the larynx of a singer a condition which, as far as one can judge from appearances, would utterly incapacitate the patient, and yet he sings in perfect voice. The larynx that makes no trouble is the one to let

alone, notwithstanding appearances, and the larynx that in function is below par is the one to treat. When a patient takes cold and the larynx becomes involved the question arises whether the inflammation of the mucous membrane of the larynx occurs primarily and the inflammation spreads to the air passages above or whether the cold starts in the nose and spreads to the larynx.

Both conditions undoubtedly occur. In children the mother often informs the physician upon his arrival that the child had a cold in the head for a few days but she thought it of little importance until the child began to cough. Adults often tell the physician the same thing. They often tell you on the other hand that the first that was noticed was a tickling in the throat and that the cold in the head occurred later. Physicians who are certainly more reliable observers than the laity have often told me that the cold made its first appearance in the larynx. In cases in which a cold in the head and larynx also occurs the pharynx often escapes any involvement. How the cold spreads from the larynx to the air passages above is a question. While it is easy to explain the secondary involvement of the larynx in a rhinitis because of the occlusion of the nostrils and disturbance of function, the explanation of the exact manner in which the inflammation spreads is not a simple matter. In cases in which the pharynx is apparently as deeply involved as the larynx ordinarily the inflammation in the pharynx will subside under treatment very much sooner than the laryngeal inflammation. Chronic laryngitis, when it exists in patients from fourteen to forty years of age is ordinarily due to some disease of the respiratory tract above. Great improvement is possible for the majority of such cases. The prognosis after thirty-five years of age is less hopeful in a given case. The habit becomes established as the laryngeal inflammation continues, and although the primary cause of the disease be removed late in life, the physician is not justified in promising any permanent benefit to the larynx. Chronic laryngitis in people over forty years of age becomes a most distressing condition. For years a patient may suffer almost continuously except during two or three months in the summer from a slight hoarseness and a slight excess of secretion in the throat. In many cases the element of cough is so slight that the condition seems to be of little importance. Unless the patient has need of a more perfect voice than ordinary he is apt to neglect himself. As age advances the element of cough increases and the condition of the patient becomes one of great discomfort. While the larynx on inspection may show next to nothing the cough interferes greatly with the patient's well-being. The patient takes a new cold with every passing breeze. The condition is incurable. Much, however, may be done to relieve the sufferings of the patient when he takes a fresh cold. A striking peculiarity of the discomfort and pain in a laryngitis is that the patient refers these symptoms

somewhat to the larynx, but much more to the upper half of the sternum. Patients constantly present themselves for a chest examination and are loath to believe that the trouble is not in the chest. Often the patient only realizes after a number of daily applications to the larynx the correctness of the opinion that the pain and discomfort arise almost altogether from the laryngeal inflammation. Nitrate of silver is the remedy in laryngeal and pharyngeal inflammation. While other astringents are useful, there is no other that, in my experience, compares with the remedy mentioned. Occasionally one has a patient whose susceptibility to the use of nitrate of silver is so great that a discontinuance of the remedy seems wise. I have in mind a patient who can stand a one-percent solution without special discomfort. The use of a two-percent solution, however, will produce a most distressing smarting that will persist for hours. My practice is to begin with a one or two-percent solution in women and a two or three-percent solution in men. If, after watching the effect of an application for a moment and finding that the solution produces no special irritation, I use the next stronger solution. I rarely use a stronger than four-percent solution in the larynx. The case that will not recover from the use of such a solution will not recover from the use of a stronger solution.

*The Hickox*

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### Practical Psychiatry

BY DR. EUGENE G. CARPENTER, CLEVELAND

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PERHAPS in no branch of the medical sciences has there been so much labor and actual advancement made in the past decade as that in the investigation of the anatomy, physiology and pathology of the brain. The success of the later methods of Golgi, Cajal and others, in showing the relationship of the cortical cells and the nerve-fibers and the nature of the "neuron unit" has thrown much light upon the mental working of the brain. The work of Wundt, Hunk and others in the school of physiologic experiment has made valuable contributions toward clarifying the correlations of the mind and the brain functions. Changes in the nerve-cells have been clearly shown by Hodge, Man, and Allen Starr, to take place after exercise and fatigue, as compared with rested cells, and this makes it all the more probable that the exact import of nerve changes and degenerations so clearly shown by Bevan Lewis and others in different forms of insanity will yet be demonstrated. The search-light of the microscope is gradually giving us a better understanding of the brain and its pathology, and divorcing us from the mysticism of the demoniacal and supernatural in which it has been so

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long enshrouded, and is establishing it upon a rational basis, alongside that of the other organs of the body. When we have been able to eliminate the fallacy of the spiritual essence of the brain, and consider it an organ, as other organs whose physiology and pathology are dependent upon a normal development, quality of tissue, blood-vessels and lymphatics, we shall have been far better able to cope with its diseases and their therapeutics. But my object in this paper is not to expand upon the subjects just hinted at, but to show how even the knowledge we have, although as yet limited, may be utilized practically in the employment of the therapeutics we have at hand. In this it has been thought fitting to attempt to offer a few suggestions on the subject of the home treatment of mental disease.

If the treatment of this class of patients in various institutions, private or public, were considered by the laity in the same light in which disease in general is considered when conducted in hospitals, then it could be laid down as a general rule that all such cases should in like manner be treated in hospitals. Unfortunately such is not the case. By reason of the occasional disasters associated with the violent insane at large, and by reason of the strange things which they say and do, anyone who is known to have suffered from mental alienation is always afterward looked at askance, feared, if not studiously avoided. To one who has recovered from such a disease this is noticeable, and is ever associated with a sense of chagrin and a feeling that he is tabooed from the social relations which he previously enjoyed. I contend, from the standpoint of observation and experience, that there are many forms of insanity which can be treated at home, and that this should obtain, especially with young men and young women, who should be saved, if possible, from the doom of social ostracism. I would not include among these the dangerous, the violent, or the intensely suicidal forms.

When is an insane person dangerous? The character of his delusions has much to do in determining this. Those having delusions of suspicion, persecution, or of being conspired against, those who feel they are being operated upon by unseen agencies, such as electricity, gases, or what not, and those who claim to be directed by the Deity or a supreme power, as God, or Christ, or that they are actually their representatives, are, as a rule, dangerous persons, and the safest thing for them and the community is to advise their being placed under the healthful restraint of some institution. Such patients always do best where they may be compelled to obey.

The *violent* include all those who, by reason of disease, have lost all mental inhibition, and have not the powers within them of controlling their thoughts and movements. They are usually boisterous, very restless, and probably disturbed to such a degree as to attempt to jump through windows or dash anything to pieces within their reach, and that without any apparent reason. With these there is a mental hyperesthesia, a very active response

to all impressions through the organs of sense. So receptive do they seem that the more they are exposed to these the more aggravated is their condition. Insanity manifested in this manner is of the rarest type, and yet every physician meets it. While this class frequently offers the surest and speediest cures in our asylums, it cannot be recommended to attempt treating them at home, unless you should succeed in early allaying their extremely maniacal symptoms. Intensely suicidal impulse is the characteristic of melancholia. It may come with the first onset of the attack, and again it may come only after long suffering without relief has driven them to a deeper determination to seek relief in self-destruction. Especially are patients to be judged suicidal from repeated attempts rather than by numerous threats. Much talk of it is a pretty sure index of little action. Suicide is, perhaps, most common among Germans and French; least common among those of the Catholic faith.

Taking the insane as a class these forms just mentioned are the exceptions. In fact, but a small percentage are dangerous, violent or suicidal. On the other hand there are many persons with the milder forms of mania, melancholia and dementia, who, with such attention as can be rendered in the ordinary comfortable home, can be safely and easily guided through the storm to the haven of a certain convalescence.

By way of illustration, a young lady aged 20 years, in a neighboring town, was suffering from mere simple mania, manifested by mild delusions, garrulousness, incoherence, paroxysms of laughter without cause, sleeplessness and mild restlessness. It was decided to send her to Cleveland, to be placed under the care of a good nurse in a private house for treatment. A mild sedative of sodium bromid, six grains four times a day, was left for her to take with a view of quieting her over-active brain, with careful instructions as to diet, exercise and occupation. Two days later the word came that the patient was much improved and they preferred giving her a further trial at home. The improvement continued, and, accompanied by her sister, she came to the city weekly for medical service. In this way her progress could be constantly observed. This was in July. Early in September she was allowed to take a trip up the lakes, after which she continued to rapidly improve, and by the holidays she returned to Oberlin College to complete the studies of the senior year.

In 1893 a young woman in the city, 23 years of age, was suffering from melancholia of a severe type. It was associated with great motor excitement, crying and wringing of the hands, constant pacing of the floor, requiring the constant care of the mother to prevent her from escaping from the house. It was at once advised sending her to our state hospital, as I regarded her as quite suicidal. The mother refused, saying she would prefer to have her treated at home, at the same time giving the assurance

that she would take the responsibility of her suiciding. Saline laxatives were given to relieve the ever-present constipation of such cases. A combination of chloral, bromid and hyoscyamus was administered to control the restlessness and to induce sleep. With the sedative we were able to tide her along in comparative quiet for a month or two, when the excited condition passed away, leaving her mildly delusional and somewhat demented. At the end of four months she had entirely recovered. In each of these cases it would have been little short of criminal to have put a blight upon these two young women's lives by sending them off to a public institution.

Another example is that of a young man in a suburban town, aged 35 years, suffering from acute dementia. Being consultant in this case, and knowing that such patients on account of their mental stupor are inactive, quiet, passive persons, that the treatment was largely a question of good care and good feeding, it was advised that he be treated in the hotel where he was living. This was undertaken and resulted in a complete recovery within a few months.

Three things should be considered in undertaking home treatment—the character of the case, the environment, and the length of the purse. As to the first, to the list including the milder forms of melancholia, mania and dementia, might be added those forms following fevers, child-birth and many helpless aged people, who are not infrequently suffering more from dotage than insanity. Then there is a class of hysterical young girls, hypochondriac young men, many mild epileptics and many forms of weak-mindedness that are better treated at home or in private rather than subjected to the mixed associations of our large institutions, or the opportunities for observation, necessarily limited, in the private sanitarium. In point of environment, there should be sufficient space and the contact of only judicious friends. The nervous and unstable are the poorest of nurses or companions. The ground floor is to be chosen as a preventive of accidents. Although at home, they should not be visited by many relatives or curious neighbors. In short, much of success depends upon the quiet of home and absence of visitors. In point of expense, Dr. Savage, of Bethlehem, London, says: "With large means any case of insanity can be treated at home, the necessity being sufficient skilled attendance by day and by night." While this is true, it refers to the severest as well as the mildest, and an expense in proportion to the demands of the case.

With the milder forms, to which this paper has especial reference, one good nurse is generally sufficient. Again, the medical treatment of the insane rests upon this tripod of essentials—*rest, sleep and nourishment*.

Rest implies much, mental as well as bodily rest. It implies control of your patient. Little promise can be offered to those who, in opposition to your advice to rest mentally, by ceasing mental labor, still keep up their daily round of work, thus ever increasing the drain upon their already exhausted energies. For those with feeble hearts and weak muscular power, especially in the aged, the recumbent position is to be secured if at all possible. If it proves irksome with some it might be alternated with light

exercise, as walking or riding. The *rationale* of the recumbent position is, to establish a better nourishing of the brain by inviting a more active circulation to it.

In the treatment of insomnia the mildest methods for encouraging sleep, such as baths, exercise before bed-time, the administration of milk, malt or hot punch should be employed. Should you be forced to the use of drugs, the mildest and least injurious should be tried first, as lupulin, bromid of sodium and trional. Failing in these, and only as a *dernier resort* combinations of sedatives come into play. Bromid of sodium, *tinct. opii camphorata*, or potassium bromid, combined with chloral and cannabis indica, or still better, the fluid extract of hyoscyamus accomplish the desired object in most instances. When there is great motor disturbance, we have at our command one drug which can be used with an assurance of positive results, and that is hyoscyamin. It should be used hypodermically in doses of a hundredth to a fortieth of a grain of the Mercks amorphous extract, or the sulphate of hyoscin found in tablets of the exact dose answer well. This drug is not dangerous in the dose indicated, but should be always used guardedly. It is most appropriate in sthenic cases.

Above all things we should be most true to the last-mentioned essential of the treatment; that is, nourishment. We can expect little or no progress if we fail in this. Most cases of insanity are anemic and lacking in good blood and fat. Only such foods should be given as are easily digested, and which tend to produce these elements of good nutrition. Chief among these are rich milk, porter, Dublin stout and eggs. The patient should be urged to take, besides the three regular meals per day, an additional glass of egg-nog or good malt midway between them.

If the physician succeeds in accomplishing these three essential points he is sure to be rewarded by the restoration of his patient in his own home in any curable case. Tonics and reconstructives can be used to the best advantage after bodily and mental quiet are restored, sleep established and the functions of the alimentary tract reinstated.

Travel in acute insanity is rarely beneficial. It adds to the excitement of the maniacal; it is unappreciated by the demented; it is but annoying to the melancholic. Brain-rest is as essential to the treatment of the acutely insane as the splint to the broken leg. Travel subserves its purpose best when reserved as a tonic to the already reinstated brain. When prescribed early in the convalescence of melancholia it has an especially salutary effect.

By way of briefly expressing the true import of this paper, viz.: that the treatment of insanity has a place and should be a part of the duties of the private practitioner, and by way of strengthening a position which may not be regarded as tenable by some, I can do no better than quote the words of Dr. Clouston, of Edinburgh, who says: "In a good hospital for the insane, most of the means of treatment, safety, skilled attendance, exercise, a properly regulated life, the administration of medicine, can no doubt be best attained; but there are the counter-balancing disadvantages of the harm to the patient's prospects from the cruel popular prejudices about asylums, and the patient's own feelings about it afterwards. If you can treat a case out of an asylum and he recovers satisfactorily, it is better for you and for him."

1416 New Eng'land Building

# Cleveland Journal of Medicine

THE OFFICIAL JOURNAL OF THE  
Cleveland Medical Society

AND OF THE UNION MEDICAL ASSOCIATION OF NORTHEASTERN OHIO

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## EDITORIAL

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### The Surgical Boomer

THE publication of a surgical case in the daily paper of one of our adjoining cities is suggestive of a considerable difference between the professional and the reportorial view of this whole subject. It is hard to keep the commercial element out of such a controversy; the newspaper always accuses the doctor of jealousy in trying to keep his rival from advertising; the physician responds by suggesting the sordid motive of the press in taking such advertising. The newspaper view is put in a somewhat seductive way in a recent editorial of the *Columbus Dispatch*. We think, however, that their arguments will hardly bear a close analysis.

The following is the gist of the matter as stated by the *Dispatch*: "The case of Dr. R. Harvey Reed calls attention to the fact that the medical profession is the only one of the once only great professions, law, medicine and theology, that still keeps up many of the old barriers of exclusiveness. There was a time when all of them wrapped themselves up in more or less of mystery, and were inclined to bid the uninitiated stand aloof. They were



as a rule very sensitive to anything that smacked of intrusive familiarity on the part of the general public. But most of these barriers have gradually given away under the leveling processes of modern inquiry and development. The professions no longer monopolize learning as they formerly did. \* \* \*

"The medical profession has been more inclined to resent this modern intrusion than the others. It has hugged its secret rites more tenaciously. It has clung more closely to its Latin formulæ. It has been more sensitive to the inquiries of the newspapers as the representatives of the people, into its doings and methods, and has been disposed to resent it as impertinent familiarity. \* \* \*

"At the same time we believe the profession makes a mistake in opposing newspaper publicity to the extent that it does. The masses of the people do not have access to medical publications. They depend almost entirely upon the daily papers for information on current events. They are interested in surgical operations and their interest is a natural and eminently proper one. If the publication of the details of an operation incidentally gives credit to the one who performs it, it does not render it any the less interesting or instructive, though it may strike a sore spot in the breasts of some physicians who chance to belong to a different school of practice or to be interested in a different school of instruction." \* \* \*

The above remarks are very plausible, but they carefully avoid the real question at issue. The whole point is whether physicians should be allowed to advertise in the daily papers. No self-respecting physician will object to the public becoming more intelligent on medical topics, especially along those lines in which their knowledge works the most good to themselves and the most harm to the income of the doctor, namely, hygiene and sanitation. That the account of such a surgical operation as that performed by Dr. Reed adds a single useful item to the knowledge of the public, I think no medical man would admit. The only end really gained is the diffusion of the name and fame of the operator. This advertising, although it passes for news, is on absolutely the same plane as the puffs which are paid for by the inch.

Why should the doctor not advertise? He is carrying on a business for gain. Why should he not carry on his business on business principles? In answer to this question it is only necessary to look at the way in which other business is carried on, especially mercantile business. Floods of paper-heeled shoes, cotton handkerchiefs, shoddy worked into hats and overcoats, give an opportunity for a tissue of lies which covers our newspapers and keeps our shops filled with people fairly treading on each other's heels in their eagerness to buy poor stuff at small prices. No one of intelligence can fail to see that the inevitable tendency of this method is more and more to sacrifice the quality of the product in order to cut under competing prices. Leaving aside all sentimental twaddle about the noble art and science of medicine, we come to the hard fact that its successful practice requires more

than the art of advertising. A long and expensive education must be supplemented by life-long study and devotion to the real interests of the sick. If the best advertiser gets the business, the best educated man, as a rule, will not. Capital cannot be devoted to getting an education and advertising, too. It rests largely with the public to say whether they wish their physicians to use their capital in acquiring knowledge or in booming the business. It is with sorrow that we acknowledge that the boomer is often the man who succeeds, but not always, and we trust that in medicine, as in some other walks of life, loudness of voice is not considered synonymous with brain power.

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### Medical Colleges and Population

THE *Tri-State Medical Journal*, in commenting upon the resolution adopted by the Ohio State Board of Registration and Examination, to the effect that no medical college would be recognized by it as in good standing which had not, in addition to other qualifications, clinical and hospital facilities based upon a minimum municipal population of 50,000, brings out some very interesting points.

In the first place, is this rule to be construed as requiring 50,000 inhabitants to each school or merely that number in one city which may have any number of medical colleges? Our contemporary thinks that to do no injustice the rule should be construed to mean that each school should have 50,000 inhabitants at its back. For instance, Atlanta has three schools in a population of 65,000, or 21,666 to each school. Will the Board recognize these schools and not, for example, the College of Physicians and Surgeons of Kansas City, Kansas, in a population of 40,000? What will it do with the graduates from the old Dartmouth Medical College, located in a town (Hanover, N. H.) of 2,000 population?

Colleges excluded by this rule are as follows: Medical College of Alabama, Birmingham Medical College, Medical Department Arkansas Industrial University, College of Physicians and Surgeons of Keokuk, Iowa, Keokuk Medical College, Sioux City Medical College, Kansas Medical College, of Topeka, College of Physicians and Surgeons of Kansas City, Kansas, Medical School of Maine, Dartmouth Medical College, Leonard Medical School of Raleigh, Willamette University, Tennessee Medical College of Knoxville, Chattanooga Medical College, Suwanee Medical School (in a town of 1,200 population!), Medical Department of Knoxville College, Medical Department Fort Worth University, and Saginaw Valley Medical College.

If the rule is construed to mean that there shall not be more than one school to each 50,000 inhabitants the medical colleges in the following cities will be debarred from recognition:

Washington 5 (1 to 46,000), Atlanta 3 (1 to 21,666), Louisville 6 (1 to 26,866), Indianapolis 4 (1 to 37,500), Kansas City 4 (1 to 33,000), St. Joseph 2 (1 to 26,000), Nashville 4 (1 to 19,000), Memphis 2 (1 to 32,500), Richmond 2 (1 to 16,000), and Columbus 2 (1 to 44,075).

It may be noted that the rule excepts specifically those colleges which receive State aid.

A CIRCULAR from the "—————Chemical Company, Factors of Pharmaceutical Specialties," which is a literary gem as well as an exponent of *fin-de-siecle* drug-making, has recently reached the JOURNAL. A few selections will indicate better than our poor words can possibly do the high tone of this circular and of the firm that issues it. On the inside of the cover we read, "We solicit trade from the dispenser direct, *be he either physician or retail druggist, to whom* we offer our best discounts and prepay delivery charges." The reckless audacity of a firm which will mail that bid for counter-prescribing to physicians is paralyzant. But to quote from our authority: "Thus far the successful treatment of cutaneous diseases has been in comparative infancy." But their remedy "has proved itself a specific in these conditions." It is "pheno-borate of ammonium incorporated with an 'unctious' base." It is good for "lichens" as well as eczema, and probably would do for mosses and fungi. It is advised to "annoint" the parts. Pil. N———, which this enterprising firm also makes, is indicated in "Neurotic or periodical manifestations of the nervous system." "In presenting this pill before the medical profession, we hesitated, on account of the prevalence in the minds of the profession, etc." So long as it was not smallpox which was prevalent in the *minds* of the profession we can be duly thankful. "We are prepared to show 90 percent of cures of cases of epilepsy, chorea or hysteria, gathered from the reports of physicians." "Pil. N——— is a certain specific in these cases." "Pil. N——— are a compound of hydroferricyanide of iron, ext. caparis carriaceæ, ext. pharodendron, with valerianate of zinc and hyoscin." "P——— is a product of the amido benzene series"—our sympathies flow out to the poor overburdened "amido-benzene series." "P——— is a specific for the *removal* of the effects of a protracted *course* of alcoholic liquors." "It produces sleep by tranquilizing the nerves, not by paralyzing them." "V——— is an efficient germicide and antizymot—" (*sic*). "It is the para-phenate of methylene and thymus, and is used in veneresl (*sic*) diseases."

As a closing rhetorical gem we are charmed with: "We make this offer to introduce our goods to those unacquainted with their merit, *and cannot be duplicated.*" It is with a sigh of relief that we are thus informed that "we cannot be duplicated."

What proportion of the profession will be hoodwinked by such a con-

glomeration of ignorance, cupidity and rascality? Despite the admitted low estate of the medical profession in America, we doubt if a corporal's guard will fail to correctly estimate at their true value remedies thus insultingly stuck in their faces.

The latter-day multiplication of small drug firms, organized purely to prey upon the medical profession, is becoming so excessive that internecine competition will ere long see most of them laid out comfortably in the necropolis of oblivion. In the meantime the profession is compelled to submit to the horrid importunities of these firms to use their products, the only recourse at present being to put the circulars (well torn up) into the waste-basket, and to kick out of the office any venturesome representative of such a firm.

Not the least of the ills brought about by this state of affairs is the distrust of all manufacturing firms which must necessarily be engendered, much to the detriment of the legitimate pharmaceutic houses.

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A CONTAGIOUS form of feeble-mindedness, called osteopathy, has struck the State of Missouri. According to the daily papers, Mrs. Senator Foraker is a convert to this new "school of medicine." All the ills of humanity from rheumatism to paretic dementia are treated and cured by appropriate manipulation of the bones. The genius who conceived this plan of treatment plunged so deeply into the study of anatomy that he discovered the human skeleton, and, being quite unable to take a superficial view of any subject whatever, it has since escaped his notice that man has other organs nearer the surface. In one case of paresis recently treated in this way a bone was replaced at the base of the skull, but from over-work since the treatment it has again fetched loose from its moorings, so that in this case the cure was not complete. All diseases, however, may be cured by this bony method.

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### Buffalo Letter

WITH the advent of October the medical circles of Buffalo are again active; college duties, society work, hospital appointments and the busy routine of private practice, all conspire to make the physician the busiest man in the community.

The fourteenth annual session of the Medical Department of Niagara University was convened on Thursday, October 1, with the largest entering class on record. This college starts the year with increased hospital and laboratory facilities, and the year bids fair to be the most successful, both to students and teachers, in the history of the university.

The opening of the Medical Department of the University of Buffalo took place September 14, 1896, the address being delivered by Dr. Woods Hutchinson, the address of welcome by Dr. M. D. Mann. The entering class is also a large one, between 75 and 80 having registered.

The dental department of the university, having outgrown its quarters in the university building, erected a new and commodious building during the summer vacation just in the rear of the university building, and opens its session on October 23. The freshman class numbers between 40 and 50 students. The department of pharmacy recently established a three-years' course, leading to the degree of Phar. M.

The Academy of Medicine began its work on September 1 with a meeting of the surgical section. The officers of this section are Dr. Chauncey P. Smith, president; Dr. Henry T. Mulford, secretary. The officers of the medical section are Dr. B. G. Long, president; Dr. I. H. Potter, secretary; of the section on gynecology and obstetrics, Dr. H. E. Hayd, president; and Dr. W. S. Arnolds, secretary.

President James D. Spencer, M. D., of the New York State Medical Society, has appointed the following Buffalo physicians on the different committees: Business Committee—Dr. Ernest Wende; Committee on Hygiene—Dr. Henry R. Hopkins, chairman, and Dr. L. Home; Committee on Publication—Dr. M. D. Mann. The next meeting of the Society will be held at Albany, January 26-28, 1897.

Dr. Ernest Wende has been elected vice-president of the National Public Health Association; Dr. William C. Krauss, secretary of the American Microscopical Society; Dr. C. M. Daniels, a member of the executive committee of the Association of Erie Railway Surgeons; Dr. William Warren Potter re-elected secretary of the American Association of Obstetricians and Gynecologists.

Dr. Peter M. Wise, superintendent of the St. Lawrence State Hospital at Ogdensburg, has been appointed chairman of the New York State Board of Lunacy Commissioners, in place of Carlos F. Macdonald, resigned. Dr. Wise is a former resident of Erie County and a graduate of the University of Buffalo.

Dr. Edward M. Brush, superintendent of the Sheppard Asylum near Baltimore, has been appointed professor of psychiatry in the Woman's Medical College at Baltimore. Dr. Brush was a former resident of Buffalo and a member of the Journal staff.

Among the prominent members who attended the meeting of the National Public Health Association, held in Buffalo September 15-18, 1896, were noticed Surgeon-General Sternberg of the U. S. A.; Albert L. Gihon, M. D., medical director of the navy (retired); Alfred A. Woodhull, M. D., lieutenant-colonel U. S. army; D. E. Salmon, D. V. S., chief of the Bureau of Animal Industry; Dr. Henry B. Horebeck of Charleston, Dr. Irving A.

Watson of Concord, N. H.; Dr. Walter Suiter of Herkimer, N. Y.; Dr. Benjamin Lee of Philadelphia, Dr. Stephen Smith of New York, and others.

Among the prominent Canadian sanitarians there were present Dr. Frederick Montizambert, of Quebec; Dr. Peter H. Bryce, of Toronto, secretary of the Provincial Board of Health of Ontario; Dr. Wyatt Johnston, of Montreal, bacteriologist to the Provincial Board of Health of Quebec.

The Mexican delegates attracted considerable attention and were an unusually active and interested body of sanitarians. Their leader, Dr. Eduardo Liciago, president of the Superior Board of Health of Mexico, was the presiding officer at the Buffalo meeting. He is also the secretary-general of the second Pan-American Medical Congress, to be held in the city of Mexico next month.

The much-talked-of German Hospital seems to be at last a reality, many of the prominent German residents of the city having interested themselves in the project within the past few months. Nineteen German physicians have so far volunteered their services on the proposed staff.

The Riverside Hospital has moved into its new home, 306 Lafayette (Bouch) Avenue, and is now housed in as neat and homelike a place as can be found anywhere.

The east wing of the Buffalo General Hospital is nearly ready for occupancy.

The Sisters of Charity Hospital, with its new and commodious north wing, presents a beautiful appearance, and now has all the complements of a great metropolitan hospital.

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### It Pays to Take Your Home Medical Journal

Many doctors have no idea of the number of inquiries which come to the local medical journal regarding the physicians living within the territory covered by such a periodical. The doctor hundreds of miles away from the home office of the journal, may be as anxiously inquired about as the one living in the building where it is published. Life Insurance Companies, Accident Companies, Bond and Security Companies, business houses and banks, corporations of all kinds and private individuals and firms write for information. The journal is looked upon as a sort of general bureau, which is drawn upon for information from all quarters. There is on the part of the journal a presumption that something is wrong with the medical man who does not take his home journal, and such *rara avis* needs to be very well known by the periodical to have its warmest endorsement. Again if the doctor pays his subscriptions, promptly, it helps to throw light upon the question so often asked about his financial standing.—*Medical Sentinel*

## OFFICIAL PROCEEDINGS

OF THE

## Cleveland Medical Society

REGULAR MEETING, September 25, 1896

*The President, DR. COOK, in the chair*

## Report of Cases and Exhibition of Specimens

DR. C. A. HAMANN

*Bromid Eruption or Mycosis Fungoides*

I desire to present this evening a case of a peculiar skin affection, or rather an affection of the skin and subcutaneous tissues. A man, 45 years of age, a watchmaker by occupation, has resided for the last 25 or 30 years in Cleveland. For eight years or more he has had epilepsy. For this he has lately, within the past two months, taken a proprietary medicine, which tastes very much like potassium bromid. A month or more ago he began to have lesions upon the skin. They began with more or less itching; at present they are elevated, rather flat, swollen disks, red in color. Some of the early lesions, I believe, are now present. These lesions gradually increased in size and suppuration took place. He became anemic. The other day he presented himself at the clinic. In regard to his family history I am satisfied that there is nothing which bears upon the case. One parent is living; the other died suddenly. His brothers and sisters are living and in good health. He had no venereal disease, neither are there any manifestations of lues about him that I can detect. The lesions are at present on the dorsum of the hand and wrist, also upon both legs. They consist of flat tabular spongy swellings, with multiple foci of suppuration, such as we see in carbuncle. Small fungoid masses protrude, and the surface presents a papular appearance. The glands of the left axilla are enlarged and slightly painful. No other glands are affected; the internal organs, as far as I can determine, are healthy, and the spleen normal. There is a decided leucocytosis. The features of the case are somewhat anomalous; as they do not correspond to those of any of the commoner affections, and, as I have seen nothing just like them, I was led to venture a diagnosis of *mycosis fungoides*, a rare skin disease. It has been called by Dühring "inflammatory fungoid neoplasm," and in its manifestations bears some resemblance to the present case. The fact that he has a leucocytosis is interesting; cutaneous lesions have been met with in cases of leukemia and pseudo-leukemia. Again, we must remember that he has been taking bromid of potash, which might be an etiologic factor in the case. I should be glad to receive any light upon the case from the members present.

DR. J. H. LOWMAN: I am reminded of an instance I saw in which potassium bromid had been given a long time and very extensive erosions developed. A man had epilepsy, and I think it was supposed also syphilis. He was given potassium bromid for a long time, and all over his body

appeared very large erosions (I think there were some twenty of them), which did not look exactly like this, but had a fungoid appearance. (Some of them as large as silver dollars.) Some of them were covered with scabs; on some there was a suppurating surface. The view was taken by some that they were syphilitic, but syphilitic treatment had no effect upon them. Finally he was treated from a purely surgical standpoint, with general medication. Each one of the ulcers was treated aseptically, and cod-liver oil was given internally. They finally went away, but I was satisfied in my own mind that they were due to bromid. Whether this is one I do not know. I think the association with bromid treatment is very suggestive.

DR. C. A. HAMANN: Upon looking up the subject of skin lesions produced by bromid of potash the only ones that I have found resembling this are described by a French author. They look as though a number of acne pustules were situated upon the surface of the lesions. These patches, however, are quite painful and are smaller than in this case. The description does not correspond with what we see here. In *mycosis fungoides* the trouble is usually more chronic, although an acute form has been described. Furthermore, *mycosis fungoides* has been found to be almost uniformly fatal. The case will be studied further and if anything is learned it will be given to the Society.

#### DR. E. G. CARPENTER

##### *Brain Tumor*

I have here a specimen of brain tumor taken from a man brought to the Cleveland City Hospital about a year ago. At that time he had a history of repeated attacks of epilepsy. He was discharged and returned a couple of weeks ago. There was then no return of the epileptic attacks, he being there but a couple of days, and suddenly died. On postmortem it was seen that there was an enlargement of the anterior portion of the first frontal lobe. It protruded forward, and on feeling the surface of the entire brain, one could easily make out a large softened spot. Examination shows this to be a small, round-celled sarcoma. Peterson, of New York, in a report of 335 cases of tumor, found that of them 166 were tubercular, 42 gliomatous, 35 sarcomatous and 37 were cysts and other mixed kinds in much smaller number. In the same series it was found that tumors of the brain occur most frequently in the cerebellum, next in the pons, next in the *centrum ovale*, after that the medulla, after that the fourth ventricle, and then the *corpora quadrigemina*. I show this specimen from the fact that the sarcomatous form is not so frequent, and on account of the peculiarity of the location. I would also mention the clinical features. When the man was received the second time there were no more epileptic attacks, but he was stupid and mentally very quiet. It looks as if this tumor originated in the membranes, perhaps the *pia mater*, and from there passed down into the brain substance, which very commonly happens in this form of tumor, and then the epileptic seizures passed off. The cortex being freed from the irritation the epileptic attacks ceased.

DR. H. S. STRAIGHT: Ten years ago I was in Vienna for a year and followed the postmortems nearly the entire time. You all know what a wonderful reputation Dr. Nothnagel, of Vienna, enjoys. He had a particular fad for diagnosing tumors of the brain, and if his inability to diagnose



cases correctly is any criterion of the difficulty of diagnosis of tumors of the brain we ought to be very patient with neurologists along this line. I would like to ask the Doctor to tell us what especially new thing as to motor areas or paths has been discovered during the past ten years.

**DR. C. J. ALDRICH:** The absence of epileptoid seizure in cases of brain tumor is something quite remarkable. I saw a case some months ago of a patient who had never had epilepsy but had had considerable atrophy and paralysis of the left arm. The postmortem disclosed a large tumor at least the size of an ordinary walnut lying in the cortex. The case would have been a very easy one to operate upon. In the later stages of brain tumor the pressure of the growth so paralyzes the function of the brain as to even inhibit the occurrence of spasm.

**DR. E. G. CARPENTER:** I would take issue with Dr. Straight. We know a great deal more about brain localization than we used to. Outside of the frontal lobes, taking especially the motor areas, we can almost certainly localize a tumor. Tumors of the cerebellum are very commonly localized. Dr. Keen, of Philadelphia, removed a small portion from the motor area in a case of Jacksonian epilepsy in which the convulsions always began in the thumb. The operation was followed by recovery.

#### DR. M. ROSENWASSER

##### *Fibroid of Uterus, Double Pyosalpinx and Empyema of Gall-Bladder*

Case I.—Fibroid of Uterus, Suprapubic Hysterectomy. Mrs. M. N., aged 42, anemic with exsanguinated appearance. Gradual development of abdominal tumor during past four or five years. Rapid growth last six months. Discomfort from increasing weight and weakness from excessive loss of blood, and from constant severe bearing-down pain. Tumor prominent, resembling an eight-months' pregnancy, reaching within two inches of the ensiform cartilage and from one iliac fossa to the other. Hard, non-fluctuating, movable, not painful. Cervix small, high up, movable with tumor. Removed September 17, by suprapubic hysterectomy according to Baer's method. Tumor a uniform fibroid mass in posterior uterine wall elongating the cavity, apparently saturated with lymph and giving sense of fluctuation; weight about 12 pounds.

Case II.—Double Pyosalpinx, removed by celiotomy. Miss R., aged 20, domestic. In good health until four months ago, when was infected with gonorrhea. Since May has suffered with profuse menstrual flow attended by severe bearing-down pain and aching in limbs. Recently constant sharp pain across hypogastrium; similar pain whenever voiding urine. In August menses lasted two weeks. Patient blond, pale, lower abdomen tender, uterus enlarged, tender, ropy mucopurulent discharge from os. Tender boggy masses at sides and behind the uterus. Curetting and celiotomy September 17, omental adhesions to pubes and *fundus uteri*. Bladder adhesions to fundus. Intestinal adhesions in culdesac and to cornua. Appendages imbedded in exudate, at same time forming roof for encysted serum low in Douglas-pouch. Tubes thickened, enlarged, highly indurated at uterine end. After tedious separation of adhesions resection of uterine cornua to save balance of uterus. Extensive oozing from severed adhesions controlled by Mikulicz tampon.

Case III.—Empyema of Gall-bladder—Cholecystotomy. Mrs. F. M., aged 36, suffering more or less for past five years with biliary colic, occasional attacks of icterus lasting two or three months. Was one of a number of cases reported cured by means of daily enemas of olive oil. Localized peritonitis in right hypochondrium from August 30 to September 7. Meanwhile formation of elongated tumor extending from beneath tender edge of liver in line with right rectus muscle to two inches below umbilicus. Recurrence of fever, slight chills and constant ache and discomfort in right side. Temperature ranging from 100° to 103°. Cholecystotomy September 20, evacuation of three ounces of pus and removal from dilated cystic duct of seven obstructing gall-stones. Rubber-tube drainage. In none of these cases has the temperature exceeded 100.5° since operation. Cases I and III have given me no worry but rallied without other complication. Mikulicz tampon removed on the 24th.

DR. W. H. HUMISTON: (Referring to second specimen). I wish to ask Dr. Rosenwasser why he did not remove the uterus. It would have been easier, and unless there was an objection on the part of the patient it seems to me the removal of a uterus in that condition would have made a more complete operation and one less dangerous.

DR. H. S. STRAIGHT

*Removal of Necrosed Bone from the Nose*

I have a case to report of a boy 14 years of age who was struck over the bridge of the nose with a piece of plate. The nose was cut pretty badly. Dr. Frank Weed took care of him. He did not remove any portion of the bone. The boy got well in two weeks and shortly after that time began to suffer from what was considered a nasal catarrh. He was brought to me four days ago. I detected a peculiar odor of the nose. Such an odor can come from foreign bodies like this, or disease of the accessory sinuses. On examination I found that the boy had a marked deviation and thickening of the septum on the right side which was very largely obstructed. I saw something peculiar and with a probe determined that it was either dead bone or a foreign body. My experience with foreign bodies is not extensive. I have seen one shoe-button in the nose and two orange-seeds. The piece appeared loose, but it was so large that although the nasal passages were thoroughly cocaineized, it could not be dragged out. This afternoon I sawed off the deviation of the septum, and I had imagined from my manipulation of the body that it was about two-thirds the size of a half-dollar. After the septum was removed we could not find it and with a probe wrapped with cotton I began an exploration of the nasal passages. The boy retched and expectorated this piece of bone. I suppose I pushed it enough so that it dropped into the posterior nares. I have not the least idea where it came from. It is evidently a piece of necrosed bone due to the injury eight years ago. The boy gives no specific history.

Program

DR. J. J. ERWIN read a paper: "Gun-Shot Wounds Produced by the Modern Rifle Ball." After reading the essay Dr. Erwin showed some slides illustrating the effect of rifle balls on bones.

Discussion

DR. P. M. FOSHAY: I perhaps did not understand clearly what Dr.

Erwin said about the theory of the explosive effect of these new projectiles at short range, and the lack of that explosive effect at longer range. As I understand by some cursory reading the explosive effect is due to the revolving of the projectile about a transverse axis in the middle, as well as revolving around the longitudinal axis. While revolving this way, of course, it hits partly "side on." It cannot perforate in a straight line. If it gets inside of the bone, it may enter at an angle that way and while in the bone tip up rending the bone apart.

DR. ROSENWASSER: This paper has covered almost the entire field of military surgery. I would call attention to one point not touched upon. We now have a new means of investigation, applicable in hospitals, which will discard the use of probes, that is the X-rays which the essayist has not mentioned, and that will very greatly facilitate finding the missile in the tissues.

DR. ERWIN: Answering the question of Dr. Foshay—when round bullets were used there was nothing to cause them to turn out of their course. The first slug or pointed bullet that was fired did; it first became unsteady, then turned with the heavy end forward. Then some one put rifles in the barrel from the effect of which the bullet could not turn because of its rotary motion. As far as producing any boring effect, or assisting penetration or aiding in producing comminution by its rotary motion is concerned, there is simply nothing in it. The comminution is produced by the immense force of contact of the bullet against the surface. It comes suddenly against something which can not get out of its way. Neither can the bullet get through without lessening its celerity, and the impact is of such force that there is pulverization not only in front of the missile but in every direction.

#### DR. ROBERT BAILEY

##### *A Case of Fracture of the Humerus Produced by Throwing a Base-Ball*

Complying with the request of a number of the members of this society, I present the case of which brief mention was made at the last meeting.

James Gray, aged 32 years, occupation metal polisher, while engaged in pitching ball on the afternoon of September 7, 1896, fractured his arm, the seat of fracture being at the upper part of the lower third of humerus. In this case there seems no reason to suspect that the bone is otherwise than perfectly healthy. The report of the fracture was heard at a distance of 150 feet and the patient himself thought he had been struck with a club. As is usually the case, this fracture is transverse or nearly so, which has simplified the treatment. Situated as it is, the *brachialis anticus* anteriorly and triceps posteriorly serve as splints which have also been supplemented by anterior and posterior outside metal splints held in place by adhesive plaster and bandage. This is the temporary or first dressing and will be replaced by permanent dressing of starch or plaster when swelling shall subside. The patient has been fully informed that a broken bone is never as good as a bone which was never broken, that in this fracture longer time is required than is necessary for union of any other bone, while liability is greater of nonunion or formation of false joint. I mention this to show how the surgeon should protect himself.

#### Discussion

DR. G. W. CRILE asked what muscles caused the fracture. Was the ball

delivered or did the arm break as the drawing-back motion was replaced by the forward motion?

DR. TUCKERMAN: A young man whom I once saw, after a long vacation pitched a match game, and although he did not break his arm, after the game was pitched a varicose condition of all the vessels of the arm came on which disabled him completely.

DR. BAILEY, in closing: The ball pitched was an "out drop curve" and I have not determined yet what muscles were in action to produce the fracture.

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REGULAR MEETING, OCTOBER 9, 1896

*The President, DR. COOK, in the chair*

Society called to order at 7:55 P. M.

Minutes of last meeting read by the Secretary, and approved.

Dr. Elizabeth Newcombe, of Oberlin, was elected to membership.

**Report of Cases and Exhibition of Specimens**

DR. C. A. HAMANN

*Bromid Eruption*

It will be remembered that at the last meeting I showed this patient. He manifested a skin lesion which was of some interest and of which we thought the diagnosis lay between *mycosis fungoides* and a lesion produced by the administration of potassium bromid. You remember that we reviewed some of the points in favor of each and finally ventured to make the diagnosis of *mycosis fungoides* inasmuch as it did not correspond to the descriptions usually given of bromid lesions. Since the last report Dr. Corlett has been kind enough to see the patient and at once recognized it as a case of skin affection due to the use of bromid.

DR. W. T. CORLETT: Through the courtesy of Dr. Hamann this extremely interesting case came under observation a few days ago. It was at once recognized as a *dermatitis medicamentosa* due to the bromin salts. The diagnosis was somewhat confirmed by the fact, elicited by Dr. Hamann, that the patient had been taking a nostrum containing the potassium bromid, and further that the eruption had slightly lessened in severity since its discontinuance. The eruption does not come under the more commonly recognized forms of the bromic eruptions, and I have not seen it in the various illustrated treatises on diseases of the skin. Morrow met with a case in 1886 which he described in his work on Drug Eruptions. Fox has also observed this form and in a personal conversation a few months ago very aptly likened the lesions to "a sponge saturated with pus." The first case of the kind that came under observation was not so readily recognized, in fact I was not aware of its nature until a year or so after he had passed out of sight—for the patient died—when the history obtained from a second case bearing a striking likeness to the one previously seen enabled me to solve the mystery.

Without referring to notes my recollection of case No. 1 is as follows: A farmer about 30 years ago entered Charity Hospital with a widely distributed, dime to half-dollar sized eruption, most abundant on the extremities, while the face remained free. The lesions were roundish, sharply defined at the margin, elevated above the surrounding skin, with a fungoid

or large papillary, honey-comb like surface from which through numerous openings pus oozed tinged with blood. For the most part the discharge had dried forming thick boggy crusts. The disease resembled a severe form of syphilis and was so regarded in spite of a negative history. The patient was an epileptic although I was not aware of his being under treatment for the same.

A thorough course of mercury, and later of the potassium iodid, failed to make any impression on the eruption, and the case passed into the hands of a colleague, who informed me he was given tonics with mineral acids to the great relief of the eruption which almost completely disappeared in a few weeks. The case made a lasting impression on me.

Somewhat more than a year later Dr. J. A. Dickson, of Ashtabula, brought in a boy about 17 years of age, with an eruption on the legs which was immediately recognized as a perfect duplicate of case No. 1. Syphilis was also considered in this case but nothing in the history pointed in this direction. That the boy had previously been under treatment for syphilis and had taken large doses of the potassium iodid led me to suspect a drug eruption. This was strengthened by the fact that Dr. Dickson had noticed an improvement in the sores when the boy was not under treatment for fits. It was finally settled that the lesions on the skin were due to the potassium bromid, and by discontinuing the drug the eruption completely disappeared.

It is not strange therefore when this case No. 3 was shown me that I knew it as one knows an old friend. The lesions are so striking, so distinctive it is hardly possible after one has seen a case to fail to recognize it again.

From a study of these three cases the following conclusions may be drawn: Aside from the more common bromic eruptions (erythematous, papulo-pustular, furuncular and ulcerative), there exists a form which first appears as a circumscribed, dark red or purplish swelling, varying in size from a split-pea to a quarter of a dollar, distinctly raised above the surrounding skin and at first giving rise to but little discomfort. In a few days there may appear on this plateau vesicles or blebs containing sero-purulent or bloody fluid. These soon rupture leaving a worm-eaten or honey-comb like surface discharging pus, sometimes tinged with blood, from numerous *foramina* (anthracoid form). This gives it the appearance of being composed of large *papillae*, somewhat resembling a cauliflower growth. The comparison to a flat sponge is very apt and quite describes the condition. When the exudation forms a thick crust it may readily be mistaken for a malignant syphilide. Again it bears a resemblance to *mycosis fungoides*. In the latter disease the course is slower, the tumors are more oval in contour and later when disintegration takes place it does not present the worm-eaten plateau of a bromic eruption.

DR. W. E. WIRT

#### *Hysterical Joint Disease*

I wish to present to this Society a rather interesting case of hysterical joint disease in an adult male.

Mr. A. L. R., aged 27, was born with a left *talipes equino-varus* of moderate severity. The foot was operated upon when he was a year old but the operation was unsuccessful, the patient still walking upon the outside of the foot. When the patient was 18 years old the foot was again operated upon, since which the foot has remained about as it is now, which you see

is nearly a correct position, there still remaining a slight varus. The patient claims that the mild turning-in of the leg and foot which we call pigeon-toe is greater than immediately after the operation, and also that it has increased since 1887. The patient has always been of a nervous disposition but was fairly well up to the age of 16, with the exception of nasal catarrh and moderate dyspepsia. Since the age of 16 he states that he has had several spells of sickness and has been more or less sick ever since. He was never strong like other young men and suffered from biliousness and constipation with headache. The patient claims always to have been a big eater and seldom lost his appetite. Patient is a masturbator.

In the fall of 1886 the patient's left ankle gave out, though he in no way injured it. He used massage for a while, after which he walked all right. On January 28, 1887, while walking out Woodland Avenue, the patient stepped on a stone the size of a chestnut, twisting his ankle. He claims to have heard something snap in his ankle and was obliged to limp the rest of the way home. The pain in walking was not great and on non-use of the joint there was no pain whatever. The next day the joint was quite swollen, with increase of temperature, but there was no ecchymosis. Massage and liniments were used and the swelling disappeared in two or three days. The patient was very careful not to hurt the joint, limping considerably, but used no appliance as a protective. In about two months he went to a physician who said that the joint had been badly sprained and for treatment wanted to blister the joint. Nothing was done at this time, though the joint continued to swell at times. One physician, an irregular practitioner, promised a cure in a few months by the use of liniments and bandaging. In May, 1887, he visited a physician who said that the bones were broken but that it was too late to correct the difficulty, but as palliative treatment suggested the use of a brace and rubber stocking, which suggestion the patient followed up to a year and a half ago, the time of my first seeing him. The patient claimed at the time of my examination that the joint was very painful on manipulation and that he could not walk without the ankle-brace. I found no increase of temperature in the joint, and no less motion than you would expect to find in an ankle joint accompanied by a club-foot cured at the age of 18. There was no increase in size of the joint as one finds in the case of a chronically inflamed joint but on the other hand a diminution in the size of the joint which is explained by the disuse from the original club-foot. I would also call attention to the fact that the injury occurred while walking leisurely and was from stepping on a stone the size of a chestnut. Under these circumstances we cannot imagine that the injury was great or that there was much tearing of the ligaments. Dr. H. T. Clapp, who referred the patient to me, has a history of a number of hysterical symptoms. I therefore at the time of examination made a diagnosis of hysterical ankle-joint disease which has since been abundantly verified. I recommended that the patient throw away the brace, that he use massage, electricity, passive motion and that within a short period he should put his full weight on the joint without the use of any artificial support. Some three or four months after my seeing him he concluded to follow my advice. He discarded the brace and rubber stocking and has been walking without artificial support ever since. The calf has increased nearly an inch in size and the joint is much stronger. The patient can take long walks without getting tired and he walks as you see with hardly any appreciable limp.

DR. ROSENWASSER: I would like to ask Dr. Wirt if among the many quacks who treated this man he came across any Christian Scientists or Faith Curers? I should think if he had struck these he would have got well.

DR. HAROLD T. CLAPP: I wish to call attention to this man's breathing. At present it is perfectly normal. When he first consulted me he had the most peculiar respiration I ever saw. Upon inquiry as to what the trouble was he said he had been told "one lung was gone." Upon examination I found both lungs in a normal condition and so informed him. I suggested that he keep his mouth closed, take long inspirations and learn to breathe naturally. When shown that he could breathe normally and informed in a positive way that his lungs were sound he gradually began to improve and at the end of a few weeks his respiratory acts were once more performed perfectly. I would further call your attention to the fact that one of our local rupture specialists has lately cured him of hernia. When he came to me he said he had a rupture, which upon careful examination I was unable to discover. Yet I believe he has paid \$75.00 for its alleged cure. In my mind this case is one in which suggestive therapeutics offers the only means of cure at our command.

DR. W. H. HUMISTON

*Cystic and Cirrhotic Ovaries*

I desire to now merely call your attention to these two specimens of diseased ovaries, which I removed by celiotomy this week. One representing enlarged cystic, and the other small cirrhotic ovaries. Both patients have an interesting history in which nervous phenomena predominate. The large ovaries are from a girl 17 years of age, and the small ones from a woman aged 44. I shall report these cases in full at a future meeting.

**Program**

DR. A. F. HOUSE

*Three Interesting Cases of Abdominal Section with Technic of Operation*

This paper appears in full on page 509 of this number of the JOURNAL

**Discussion**

DR. H. S. STRAIGHT: I would like to know a little more definitely about that growth that was possibly in the ureter.

DR. W. E. WIRT: I wish to ask the doctor if he ever put the part that he operates on, in soft soap or soap liniment over night. They do, I believe, carry out that rule in New York. In the morning the epidermis is all softened and can be very thoroughly prepared for operation. I think it is an excellent method.

DR. W. H. HUMISTON: I think in the preparation of the abdomen a great deal too much fuss is made. I never yet had a case lie all night with a damp cloth over her belly and I believe 99 cases out of a hundred get along without suppuration in the abdominal wound without this. I think if the patient is thoroughly bathed and the pubes shaved the day before and another bath in the morning and the usual preparation while on the table

under the anesthetic, that is all that is necessary. I find there is danger of a wet pack over the abdomen giving cold and causing complications.

DR. ROSENWASSER : I would ask a question as to the removal of gauze from a pus cavity. I refer to the first case, in which there was a pus cavity that was thoroughly cleansed and then packed with gauze. After two days this was removed and the abdominal wound closed. Now we know that no pus cavity can be thoroughly sterilized, and the probability is that some pus or pus germs will be left in the cavity; and the established practice is to remove the gauze and either put in fresh gauze or a drainage tube. I question whether the early removal of the packing and immediate closure is a safe procedure.

DR. A. F. HOUSE : In regard to Dr. Straight's question, I will say that I did not call this a tumor or a foreign body in the right iliac fossa. Dr. Stamm made the remark on manipulating the part, that "it seemed as though there were a foreign body in the right ureter." I don't believe it was. I believe it was simply an exudate.

I believe as Dr. Humiston does, that it is not necessary to apply a soap poultice for 12 or 24 hours to the abdomen previous to operation. If you make a good thorough scrubbing with German green soap and a flesh brush thoroughly applied a few hours previous to the operation at the time of shaving the pubes, later on after the patient is anesthetized a second scrubbing is all that is necessary. I am not bothered with stitch-hole abscesses. In this case the uterus was freely movable, and I think the doctor has got my first and second case mixed.

I said in my paper, "The abdominal wound was now closed up to the gauze drainage. I then removed the gauze I put in first, then packed with Mikulicz tampon and left for 48 hours." I found no oozing and no reason why I should repack it. The cavity was thoroughly sponged out and as much of the mass as possible removed.

DR. E. G. CARPENTER

*Practical Psychiatry*

This paper appears in full on page 518 of this number of the JOURNAL

### Discussion

DR. H. S. UPSON : This subject seems to me one of the most difficult problems that a physician has to deal with. He is between two fires in the matter. As Dr. Carpenter has said the cases of general paralysis, of paranoia and of mania are the ones to send to the asylum. The cases of mild melancholia are the ones that can best be treated at home. And yet, these cases present the greatest danger to the patient and to the friends. In the case of a maniacal person the friends are at all times prepared for an outbreak. The melancholic keeps things to himself and broods over them and the outbreak comes when it is least expected.

In contradistinction to some of the cases related by Dr. Carpenter, I recall some recent experiences which are not quite so pleasant. I remember one case of a woman who during lactation developed simple melancholia. We could not get at any definite delusions. I did not think I was justified in sending her to an asylum. About a week afterward her husband was shaving one morning and stepped out of the room for a moment. She got



the razor and cut her throat. I recall another case of a man who was very much depressed. He had been melancholic for about a year and a half. His trouble was connected with marked digestive disorder and he had a few ideas which you might call delusions. That is, they were fixed ideas of the hypochondriac type. He was under my care for a time and then went to Dansville and was under treatment there several months. He came back somewhat improved and after being under observation for a short time committed suicide. In that case I would have had great hesitancy in going into court and swearing that the man was insane. He was one of those cases that talk suicide but very rarely kill themselves, and was one of the exceptions which prove the rule. One or two experiences like these lead one to great caution in handling these cases, and yet the physician must take the responsibility of putting on them the stigma of asylum treatment or incurring the risk of violence under home treatment.

**DR. A. R. BAKER:** I presume the unfortunate experience of the eminent neurologist, Dr. Seguin, is familiar to you all. He read a paper some years ago in which he urged the necessity of treating these cases at home. Shortly afterward his wife became insane and he attempted to put his theory into practice. One day she took her three children up stairs and hung them and herself. I think it is rather a dangerous practice and it would be better for physicians to try to combat this idea that it is any more disgrace to send a patient to an insane asylum than to a hospital. I think the change of name from "asylum" to "hospital" in this State a good one.

**DR. C. J. ALDRICH:** It seems to me that there is nothing more uncertain than the action of a man with a diseased mind. The family nearly always insist that the patient is not as bad as other people think he is. If you care for him in the family you have that prejudice to combat. This reminds me of a case Dr. Rosenwasser and I had something to do with. It was a case of a girl about 17 years of age. She persisted in tearing her clothes all off and singing "Down Went McGinty to the Bottom of the Sea." This case developed all the devilishness that the hysteric insane are capable of manifesting and we had little success in treating her for the simple reason that the family insisted she ought to be treated like a sick person. But the mother became very much enraged one day and seized a strap her husband stropped his razor with. She whipped that girl into a correct frame of mind within half an hour. That simply illustrates what we have to deal with in the way of combating the prejudices of the family.

**DR. M. ROSENWASSER:** I rise to say something on the etiology rather than the treatment. The wife of a physician was taken at midnight with acute mania. This was about two weeks after confinement. A neighboring physician was called in by the husband. Nothing was of benefit but inhalations of chloroform. I was called to see her in the morning. I advised giving a hypodermatic of  $\frac{1}{4}$  grain of morphin. This dose was repeated in half an hour, and she slept for six hours. The history was as follows:

This woman from the time she was three months pregnant could not sleep and consequently began to inhale chloroform taking it on a handkerchief three or four times a night; she continued this during the entire pregnancy, claiming that just as soon as she was over her pregnancy she would discontinue the habit. She insisted on attending herself during her confinement. Within a week she was up and about. Toward the end of the second week she had been out riding with her husband and he noticed that

her talking was occasionally incoherent. He thought this was due to discontinuing the chloroform. The sudden attack of mania followed at midnight. At my first visit she was not feverish. I advised early removal to an asylum if she continued violent. In the meantime she developed quite a fever, 104° the following morning, 107° in the evening. We expected she would die in a day or two. We could not get her to take anything. Rectal feeding was resorted to during deep narcosis. Dr. Eyman was called and advised the use of hyoscyamin in connection with morphin. When the fever came on we decided to keep her at home. We did not know how much the chloroform habit had to do with her condition. I made a pelvic examination and found no tenderness or gross evidence of septic infection. As soon as she could swallow we administered cathartics and she finally passed large quantities of intensely offensive fecal matter.

We have here three etiologic factors; the auto-infection which alone might have led to the mania; the puerperal condition might have done the same thing and the chloroform habit might have contributed. The patient was treated as a case of meningitis. It was the only diagnosis admissible. She had had no preliminary symptoms. Simply this intense delirium and hallucinations and the high fever. Gradually after three weeks she became more rational and finally she made a complete recovery.

I wish to say a word about hyoscin. We tried hyoscyamin and found that it had a little better effect than hyoscin. We also tried using it alone and it did not have a good result. We tried morphin alone and it did not have as good result. It was the combination that had the most soothing effect.

DR. E. G. CARPENTER: Being in an asylum is no guarantee against suicide. I have known patients to hang themselves on the bedstead, to pick up a piece of steel stave and cut the jugular vein, and kill themselves in various ways. Considering the whole number of these melancholics at large, I think the percentage of suicides is really small.

Dr. Rosenwasser's case points, I think, to auto-intoxication. I saw in Vienna under Kolisko a postmortem of a case which had been treated in an asylum. The man was becoming much better. Suddenly he took on acute maniacal symptoms and died of exhaustion. At the postmortem there was fully a peck of feces taken from his intestines. I believe myself that almost all cases of melancholia are due to auto-intoxication and some good men in New York say they are curing 90 percent of them by treating them along that line. As to hyoscyamin, Merck's amorphous is the best but it comes high. The sulphate of hyoscin can be used to good advantage. Perhaps one case in a hundred hyoscyamin aggravates, but as a rule after giving it, one can get the patients' attention and as it makes them very thirsty you can get them to take a great amount of nourishment.

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#### THE BARNES MEDICAL COLLEGE AND THE CLEVELAND MEDICAL JOURNAL

*The Cleveland Medical Journal* is away off in its reference to the Barnes Medical College, of St. Louis. It has been imposed upon. The Barnes Medical College has employed no legal talent to fight any stated board and does not object to any standard as too high, agreed upon by the Medical profession. Malicious minds have made such statements for some inscrutable purpose.

The Barnes Medical College students pass all State Boards.

[Advance Editorial in *Alienist and Neurologist*.]

## The Mahoning County Medical Society

THIS Society, at its Eighth Annual Banquet, October 15, celebrated the fiftieth anniversary of Morton's first public demonstration of surgical anesthesia. President Jared E. Cone, M. D., opened the meeting by presenting Dr. R. Stansbury Sutton, of Pittsburg, who reviewed the history of medicine from early times to the present, and dwelt especially upon the advance in surgical knowledge and practice since the introduction of anesthetics.

Dr. Howard S. Straight, of this city, then read a paper upon laryngitis which is published in full in this JOURNAL. The Society then adjourned to the banquet room.

Those present were: Drs. F. E. Bunts, Howard S. Straight, N. Stone Scott, John P. Sawyer, C. B. Parker, W. E. Bruner, W. E. Wirt and George W. Crile, of Cleveland; Dr. R. S. Sutton, of Pittsburg; Dr. C. R. Justice, of Poland; Dr. W. P. Arner, of Fowler; Dr. W. H. Button, of Hubbard; Dr. J. H. Reed, of Sharon; Dr. J. A. Blair, of New Castle, Pa.; Dr. H. E. Zimmerman, of Mt. Jackson, Pa.; Dr. C. S. Ward, of Warren; Dr. D. D. Campbell, of Canfield; Dr. A. J. Leitch and Dr. A. M. Beach, of Niles; Drs. J. E. Cone, H. H. Hawn, John McCurdy, H. E. Welch, Arthur Winter, Byron Williams, S. A. Reilly, R. E. Whelan, R. H. Montgomery, R. D. Gibson, C. F. McBride, R. H. Barnes, L. U. Howard, J. S. Zimmerman, Carlos C. Booth, A. C. Wilson and A. M. Clark, of Youngstown.

Dr. Cone gave the address of welcome which was followed by the banquet proper.

Dr. John McCurdy acted as toastmaster. The first toast was "Anesthesia" responded to in an excellent paper by Dr. J. J. Thomas, of Youngstown. Dr. C. B. Parker, of Cleveland, discoursed upon the "X-Rays." Dr. L. A. Howard appropriately toasted "The Ladies." In the absence of Dr. Montgomery Linville, of New Castle, Pa., who was to respond to the toast "Wheels" Dr. Carlos C. Booth was asked to fill his place. He responded by saying: "Wheels are the only thing I have; don't ask me to give them away." After a few impromptu toasts a very successful and pleasant meeting was adjourned.

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### THE CLEVELAND JOURNAL OF MEDICINE

The following table of contents for September of this bright up-to-date journal speaks for itself. \* \* \* The articles are all good, and the editorial style and conduct unsurpassed in American medical journalism.—*Moody's Magazine of Medicine.*

## Medical News

**Hog Cholera** is raging with much ferocity in the Ohio Valley.

**Dr. Charles A. Snow** of Garrettsville was in the city October 19.

**Dr. Dudley P. Allen** is engaged in some scientific work in Germany.

**Dr. Herman Bauer** of 1460 Willson Avenue, has returned to Germany leaving his family here.

**The public schools** at Newark were closed October 21 by reason of a severe epidemic of diphtheria.

**Dr. C. S. Ward** of Conneaut attended the meeting of the Cleveland Medical Society on October 23.

**Dr. A. F. Spurney** sailed for France early in October. He will do some work in foreign medical institutions before returning.

**Dr. J. W. Morgan**, of Alexandria, Ind., 71 years of age, died October 14 from the effects of drinking carbolic acid by mistake.

**Dr. James M. Gassaway**, Surgeon in the Marine Hospital Service with present station at Cairo, Ill., was in the city October 9 visiting friends.

**Dr. A. B. Howard** of Cuyahoga Falls, Superintendent of the Fair Oaks private retreat for mental diseases was in the city October 22.

**Dr. R. M. Woodward** surgeon in charge of the Marine Hospital in this city, addressed the Tri-County Society at Ashtabula, November 10, upon hernia.

**Dr. C. W. Hanford** representing the well-known firm of Victor Koechl & Company, is at present making his periodic visitation to the profession of this city.

**Dr. D. F. Donaldson** of Port William, near Wilmington, this State, has been sued for \$10,000 damages for alleged malpractice in treating a dislocated shoulder.

**Dr. S. J. Wright** of Tallmadge was in the city on Saturday, October 14. He reported more activity in politics than in medical practice in his section of Summit County.

**Dr. J. E. Cook** and Dr. N. M. Jones have moved their offices from the corner of Franklin Avenue and Pearl Street to the new Foote Building on Pearl Street near Detroit.

**The State Board** of Pharmacy made its annual visitation to Cleveland October 12 for the purpose of examining applicants for pharmacist's license, and found 115 applicants awaiting it.

**Dr. S. S. Burrows** late Superintendent of the Blind Asylum at Colum-

bus, now resuming his old practice at Geneva, attended the October 23 meeting of the Cleveland Medical Society.

**Vermont** has under consideration in its State Legislature at present a bill providing for a state board of medical examiners which seems to have been modelled closely after the Ohio law.

**The Medical** students of the city find it convenient to pay Case Library its \$1.00 a year dues and thereby obtain access to the books and periodicals of the Cleveland Medical Library Association.

**Dr. T. V. Lyons**, of Miamisburg, died October 6, at the age of 67 years. He had retired a few years since after practicing over 30 years. He was a prominent and highly respected citizen.

**Cleveland Physicians** will be interested—or amused—by the following clipping from the *Fort Wayne Journal* for October 10. The new medical law of this State may have some bearing on the matter.

"Dr. E. P. Banning has been for several days at Cleveland putting in some work in the preparation of his forthcoming book, 'Pathology and Therapeutics in Spinal and Other Orthopedic Derangements.' Importunate publishers have been pressing the doctor for 'copy' and there was no resisting. Dr. Banning may return to Fort Wayne today, but in any event will be here by Monday."

**Diphtheria** is actively epidemic in Bucyrus wherè a number of cases arose among those who attended the funeral of the first victim. The Board of Health is doing its best to arrest the spread of the disease.

**Dr. James Goodpastor** of Portsmouth, has retired to the Columbus penitentiary for a few years to meditate upon the consequences of criminal abortion. This is rapidly becoming a dangerous occupation.

**Dr. O. W. Weeks** of Marion, according to the papers, has been appointed a delegate to the Pan-American Medical Congress which meets in Mexico this month. He was formerly Surgeon-General of the G. A. R.

**Dr. R. H. Hanna** of Warrington, Indiana, died October 14 of occlusion of the bowels, following an overdose of opium taken to combat a severe attack of acute insomnia. He was a native of Brown County, Ohio.

**Dr. W. W. Brand** of Toledo, the capable correspondent of the *JOURNAL* in that city, was confined to his bed with an attack of pneumonia the first two weeks in October. It is a pleasure to state that he is now thoroughly convalescent.

**Dr. J. H. Leatherman**, a homeopathic physician of Columbus, was arrested October 9 on a warrant issued by the State Board because he had failed to register under the law. The papers say his will be made a test case against the law.

**Dr. B. S. Higley**, one of the assistants at the Cleveland State Hospital for the Insane recently resigned. On October 21 the Board of Trustees at its regular monthly meeting elected Dr. A. J. McNamara of Bridgeport, Conn., to fill the vacancy.

**The Dental Department** of Western Reserve University celebrated the occupation of its new quarters in the Bangor Building by giving a well-attended public reception on the evening of October 15. The school opens the year in most prosperous condition.

**Dr. Hosea W. Libby** of this city, according to the papers, having been refused a certificate to practice medicine by the State Board, has brought mandamus proceedings against the Board in Columbus courts to compel them to issue a certificate. He alleges to have practiced medicine 42 years in Ohio and 39 in Cleveland.

**The following** advertisement appeared in the *St. Louis Globe-Democrat* of October 7, 1896:

Dr. I. N. Love, his family being in Europe for the next two years, has rented his residence, furnished, and removed his offices to the first floor of the Medical Mirror Building, 3507 Olive Street. Hours, 9 to 11 and 5 to 6. Sundays by appointment only. Telephone 7171.

**The National** Normal University of Lebanon which has heretofore graduated physicians after a three-years' course has cheerfully acquiesced in the new rule of the State Board in regard to minimum population necessary to adequately teach medicine. They have, however, applied for and received permission to conduct a preparatory medical course covering two years' study, as they have good laboratory facilities.

**"Official Check"** is what the editor of the *Cleveland Journal of Medicine* calls the request of the treasurer of the American Medical Association for five dollars in payment of the annual dues for 1896. As the Association has declared that the members of the Cleveland Medical Society are no longer to be recognized as in good standing in the Association, this characterization of a demand for dues would not appear to be unjustified.—*Medical Record*.

**The National** Professional Art Printing Company of this city which makes a business of printing large engravings of pictures of professional men proposes to get up a picture of the Cleveland Medical Society. This would seem to be a very desirable thing, as this Society is today one of the best known in the United States and a collection of the faces of its members at this period of its existence will be of more than ordinary interest. It is to be hoped that the project will be a success.

**Dr. William R. Gillespie**, a graduate of the Medical College of Ohio in the class of 1887, member of the Southeast Kansas and Bourbon County Medical societies (Polk's Register) and Dr. B. W. Seymour of unknown

credentials advertise in the daily press that they are prepared to use the "X-rays" upon all persons applying for the same at their offices in the Permanent Block. Broken bones, curvature of the spine, dislocated joints, hip-joint disease, club feet, bow legs, enlarged joints, white swelling, necrosis, bone cancer, tumors, obstructions of the bowels and "appendicitis or other lodgement of foreign bodies" are advertised to be amenable to the "X-rays."

**The American Association** of Obstetricians and Gynecologists at its ninth annual meeting held at Richmond, Va., elected the following-named officers for the ensuing year, namely: President, James F. W. Ross, M. D., Toronto; vice-presidents, George Ben Johnston, M. D., Richmond, and John C. Sexton, M. D., Rushville, Ind.; secretary, William Warren Potter, M. D., Buffalo; treasurer, Xavier O. Werder, M. D., Pittsburg. Executive council: Charles L. Reed, M. D., Cincinnati; Lewis S. McMurtry, M. D., Louisville; A. Van der Veer, M. D., Albany; J. Henry Carstens, M. D., Detroit; and William E. B. Davis, M. D., Birmingham.

The next annual meeting was appointed to be held at the Cataract House, Niagara Falls, N. Y., Tuesday, Wednesday, Thursday and Friday, August 17, 18, 19 and 20, 1897.

**Dr. John B. Hamilton** who was ordered to San Francisco by Dr. Walter Wyman, supervising Surgeon-General of the Marine Hospital service, appealed to Secretary Carlisle for modification of the order on the ground that he had been promised eight years in Chicago of which five only have elapsed. The Secretary declined to interfere, however. October 10 was the date finally set upon for the change, but in the meantime Dr. Carrington who had been ordered to relieve Dr. Hamilton October 1 arrived in Chicago, and Dr. Hamilton was really relieved of the hospital service on the third day of the month. He contracted a severe cold which developed into an acute bronchitis and confined him to his bed for the best part of ten days. Having no recourse he telegraphed his resignation from the Service to the President on October 13. In the newspapers he charged Dr. Wyman with having driven him out of the Service for personal and political reasons. His resignation was accepted and the Service has lost one of its oldest and most efficient members.

**An interesting** meeting of the State Board was held October 6 at which four physicians were examined and protests against the registration of several physicians were heard. The Board does not propose to grant licenses to physicians who habitually use intoxicants.

The Board has done some good work this summer. Up to October 7, 6,567 graduates in medicine have received certificates, 588 "ten-year" men had qualified and 236 applications had been rejected—a total of 7,391. On the same date about 100 applications from "ten-year" men were pending. As the last edition of Polk's Register gives the names of but 7,560 physicians

in the State it would seem that within less than 100 of all the physicians of the State had been attended to. But Dr. Winders, the Secretary, reports that Polk's Register is replete with omissions and other errors so that little dependence can be placed upon it, and, in passing, it may be noted that the journals all over the country are pointing out numerous errors in the Register.

**Dr. Josephus Craft** of 64 Streater Avenue, this city, died October 18, of paralysis, at the age of 55 years. Five weeks previous to his last illness he was injured while driving with his brother in Ashland County by being thrown from the buggy. He partially recovered but two weeks later, after his return home, he suffered a severe hemiplegia, from which he died three weeks later.

Dr. Craft was born in western Pennsylvania, but lived in Ashland County, this State, for most of his early years. He graduated from the Charity Hospital Medical College, subsequently called Medical Department of University of Wooster, now Cleveland College of Physicians and Surgeons, in 1867. He practiced for a time at West Salem, where he married Miss Clara J. Humiston, sister of Dr. W. H. Humiston, in 1874. For twelve years he practiced at Worthington, Minn.; returning to this city in 1886. His wife, a son and daughter survive him. He was a member of the Cleveland Medical Society and of the Cuyahoga County Medical Society. He was a Mason, and a consistent member and official of Beckwith Memorial Presbyterian Church. The funeral and interment took place October 20, and were attended by a large concourse of friends.

**Early in the** summer some of the druggists of this city thought it would be a good joke to apply to the Board of Medical Registration and Examination for licenses to practice medicine on the basis of having had ten years' practice—meaning no doubt "counter-prescribing." The following are the jokers: Fred W. Stecher, 1066 Pearl Street; Michael Gerstacker, 253 Whitman Street; George J. Probeck, 94 Duane Street; Kent P. Humiston, 546 Lorain Street; Philip Acker, 252 Pearl Street; E. H. Hechler, 1099 Broadway; Carl C. Walz, 602 Pearl Street; L. H. Witte, 350 Superior Street, (Homeopathic); and F. H. A. Diemert, Woodland and Eagle Street.

The latter two are the only ones who succeeded in getting licenses however, so that the \$5 joke is not on the Board to any great extent. C. H. Kohler, a saloonkeeper at 132 Summit Street, applied for license but drew a blank. It is a pleasure to state that one of our most notorious abortionists, a masseur, an ignorant hydropath and a "corn doctor" have among some 25 others been refused licenses. This good result of the law, however, is somewhat offset by the fact that licenses have been granted to some of our most notorious quacks. Even a professed "botanic" and a "Baunscheidtist" were so honored, the latter, however, because he honestly possessed a diploma from one of the regular schools of this city.



# Condensed Table of Mortality in Cleveland for September, 1896

By courtesy of Dr. J. L. Hess, Health Officer

## I.—FEVERS.

Influenza.....	0
Typhoid.....	16
Scarlet fever.....	1
Measles.....	0
Diphtheria.....	12
Varicella.....	0
Remittent fever.....	1
Intermittent fever.....	0
Cerebro-spinal.....	0
Erysipelas.....	1
	31

## II.—DISEASES OF THE NERVOUS SYSTEM.

Marasmus.....	18
Meningitis.....	13
Softening of brain.....	2
Abscess of brain.....	0
Apoplexy.....	6
Epilepsy.....	2
Tumor of brain.....	0
Sclerosis of brain.....	0
Hydrocephalus.....	0
Aneurism of brain.....	0
Tetanus.....	0
Anemia of brain.....	1
Cerebral embolism.....	0
Myelitis.....	0
Dentition.....	1
Convulsions.....	18
	61

## III.—DISEASES OF RESPIRATORY SYSTEM.

Croup.....	7
Croup—membranous.....	3
Bronchitis.....	10
Phthisis.....	28
Pneumonia.....	17
Pleurisy.....	0
Congestion of the lungs.....	4
Edema of the lungs.....	1
Gangrene of the lungs.....	0
Tuberculosis.....	14
Cancer.....	8
Empyema.....	0
Asthma.....	1
Emphysema.....	0
Whooping cough.....	5
	98

## IV.—DISEASES OF THE DIGESTIVE SYSTEM.

Perforation of intestines.....	0
Strangulated hernia.....	0
Gallstone.....	0
Gastritis.....	7
Gastric ulcer.....	0
Cancer of liver.....	0
Cancer of stomach.....	4
Enteritis.....	4
Peritonitis.....	5
Appendicitis.....	2
Obstruction of intestines.....	4
Diarrhea.....	2
Dysentery.....	1
Cholera Infantum.....	14
Enterocolitis.....	5

Cholera morbus.....	1
Jaundice.....	2
Hepatitis.....	0
Acute yellow atrophy.....	2
Abscess of liver.....	2
Cirrhosis of liver.....	2

57

## V.—DISEASES OF CIRCULATORY SYSTEM.

Dilatation of heart.....	0
Fatty degeneration of heart.....	1
Rupture of heart.....	0
Pericarditis.....	1
Endocarditis.....	9
Myocarditis.....	1
Valvular disease.....	4
Aneurism.....	1
Fibroids.....	0
Anemia.....	1
Fernicious anemia.....	0
Pyemia.....	0
Septicemia.....	6
Puerperal fever.....	0
Rheumatism.....	2
Rickets.....	0
Syphilis.....	0

26

## VI.—URINARY DISEASES.

Nephritis.....	3
Acute Bright's disease.....	1
Chronic Bright's disease.....	0
Cystitis.....	1
Diabetes.....	0

5

## VII.—GENERATIVE SYSTEM.

Postpartum hemorrhage.....	0
Cancer of breast.....	0
Cancer of uterus.....	1
Puerperal eclampsia.....	0

1

## VIII.—VIOLENT CAUSES.

Accident.....	15
Suicide by hanging.....	0
Suicide by shooting.....	0
Suicide by poisoning.....	1
Suicide by drowning.....	1
Homicide.....	0
Asphyxia by overlying.....	0
Burns or scalds.....	1
Railroad injuries.....	6
Gunshot injuries.....	2
Shock.....	1

26

## IX.—UNCLASSIFIED.

Inanition.....	32
Premature birth.....	1
Senile debility.....	21
Alcoholism.....	1
Sunstroke.....	0

55

Total deaths for September, 360. Total deaths for September, 1895, 449.

Annual death-rate per 1000 during the month (estimated population 330,279) 13.264.

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No. 12

## Lumbar Puncture of the Subarachnoid Space with Report of Cases

BY RALPH JAY WENNER, M. D.

*Visiting Physician to St. Clair Hospital; Visiting Physician to  
The German Hospital*

LUMBAR puncture of the subarachnoid space was first performed by Quincke on man in 1891, and described by him shortly after, his object being at that time to relieve the pressure symptoms of hydrocephalus. The operation being more simple and much less dangerous, was intended to take the place of trephining or puncture through the fontanelle. As a therapeutic measure the operation has seemingly proved a failure, but Lichtheim, in 1893, published an article in which he called attention to its undoubted value as a diagnostic agent. If strict asepsis and antisepsis are observed there is practically no danger connected with the operation. In my cases I used an ordinary small-sized aspirating needle, sterilized, without the syringe being attached. It is necessary, of course, to be very careful in inserting the needle, as in several cases, by too free manipulation, the needles have been broken off and left sticking. When the needle strikes an obstruction it is always well to partially withdraw it before reinserting, and it may even be necessary to choose a new site. The needle is inserted in the adult between the third and fourth lumbar vertebræ, and in the child between the fourth and fifth. There is no danger of wounding the cord, for in the adult it only extends to the first lumbar vertebra, and in the child to the third. The danger of wounding the nerves is nil, as these are so tough that the needle readily glances off from them. In the child the needle may be inserted between the spinous processes in the median line as the processes are usually widely separated, but in the adult the puncture is made about a

finger's breadth to the side of the spinous process, the needle being directed slightly upward and inward.

The depth of the insertion varies from 2 cm to 8 cm. The amount of fluid withdrawn may vary from a few ccm to 100 ccm. The fluid may come away drop by drop, or with a spurt, thus indicating the condition of cerebral pressure. In my cases raising the head and shoulders caused the fluid to flow more rapidly. The patient should be placed in a position to give the greatest possible convexity to the spinal column, thus giving prominence to the spinous processes, which should be marked and counted several times, from above downward, to insure against any mistake in location. It is claimed that a line passing through the *cristae illi* invariably passes through the body of the 4th lumbar vertebra. (Jacoby *N. Y. Med. Jour.* Dec. 28-95).

In the majority of cases an anesthetic is not necessary, but where there is much muscular rigidity, cutaneous hyperesthesia, or convulsions, it is much safer to have the patient anesthetized. The after-treatment of the site of puncture consists in covering the spot with iodoform-collodion.

What are the possible dangers attending the operation? Infection of the site of puncture may occur. The needle may by injudicious manipulation be broken. In three cases of cerebellar tumor reported, death followed the puncture in from 6 to 40 hours, but it seems to me manifestly unfair to take it for granted that the puncture was the cause of death, for cases of cerebellar tumor die when not punctured.

Wentworth reported his first case of lumbar puncture in the *Boston Medical and Surgical Journal* December '95, in which, after 5 or 6 ccm of fluid had been withdrawn most alarming symptoms occurred; the pulse rose to 250 beats per minute, (by stethoscope) the patient screamed and was restless, the extremities were cold, and the color bad. This condition passed away in about 30 minutes, and the patient made a good recovery in a few days.

As a therapeutic agent, the operation has seemingly not been attended by great success, although attempts have been made by Caille (*Archiv Pediatrics* August, '96) to medicate the parts directly affected in tubercular meningitis, through the lumbar puncture. Remembering the mysterious effect celiotomy has upon a tubercular peritonitis, we will wait anxiously the result of his experiments, hoping that the means are at hand by which we will be able to strike this dread disease, the diagnosis of which as Jacoby says is a death warrant, on its own soil, and in its own stronghold. It is also claimed that withdrawal of fluid through a lumbar puncture, relieves the extreme headache of brain tumor, although for a short time following the puncture the pain is more severe.

Jacoby (*N. Y. Med. Jour.* Jan. 4th, '96) reports two cases of spinal meningeal hemorrhage due to injury, followed by paralysis of the lower extremities, loss of control of the sphincters and so forth, in which puncture, per-

mitting the escape of bloody fluid, was followed by complete recovery in one case, in the other case weakness of the peronei and extensors, and loss of knee-jerk remaining.

As a diagnostic agent, withdrawal of fluid from the subarachnoid space demands the attention of every diagnostician, for along this line it is no longer an experiment. Autopsies confirming diagnoses have been made sufficient in number to warrant its being placed in the front rank as an aid in the diagnosis of certain diseases of the brain, and possibly of the spinal cord. The only case of tubercular meningitis recorded, in which the diagnosis was made positively, terminating in recovery, is reported by Freyhan. In this case two punctures were made, a week apart, tubercle bacilli being found each time (Wolfstein *Archiv Pediatrics* Mar. '96). The search for tubercle bacilli is sometimes a tiresome procedure requiring plenty of patience and perseverance. In one case that I know of, 50 slides were examined before one bacillus was found. It is always well to clinch the diagnosis by animal inoculation and cultures.

The summary of Dr. Wentworth's paper on puncture of the subarachnoid space (*Archiv Pediatrics* Aug. '96) is so terse and to the point, that I will give it; 1. "The normal cerebrospinal fluid contains neither cells nor fibrin, and is perfectly clear.

2. In cases of meningitis, the cerebrospinal fluid is invariably cloudy when withdrawn. The degree of cloudiness is to some extent proportionate to the amount and character of the exudation in the meninges.

3. The cloudiness is caused by cells. The character of the cells differs with the variety of the meningitis. After withdrawal more or less of fibrin is formed in the fluid. The presence of these cells and fibrin is pathognomonic of inflammation in the meninges.

4. The cloudiness is oftentimes so slight that close inspection is necessary to detect it.

5. The operation is not difficult to perform on infants and young children. It is not dangerous if strict cleanliness is observed.

6. The differential diagnosis between the different kinds of meningitis can be made by microscopic examination of the sediment, by cultures taken from the fluid, and by inoculation experiments.

7. Inoculation experiments afford the surest way of determining tubercular meningitis. It is of value to distinguish between the different varieties in order to ascertain if tubercular meningitis is recovered from.

8. In normal cerebrospinal fluid a faint trace of albumin is present, about 1-50 of one percent or less, by quantitative analysis. In meningitis, the amount of albumin is increased, and has varied from 1-30 to 1-10 of one percent.

9. In one case, a diagnosis of general infection with *staphylococcus*

*pyogenes aureus* was made from cultures taken from the cerebrospinal fluid."

Lichtheim has constantly found varying quantities of sugar, in cases of tumor of the brain, and seems to regard a considerable quantity of sugar in the cerebrospinal fluid, proving the patient is not a diabetic, as a circumstance which would lead one to suspect tumor of the brain. On tubercular meningitis examination of the blood will often throw considerable light, for in this disease, unaccompanied by suppuration, the number of leucocytes rarely exceeds 10,000, as has been demonstrated by V. Limbeck. If there be a slight increase in the number of leucocytes, it is usually of the small mononuclear variety known as lymphocytes. In cases of tubercular meningitis, the cloudiness of the cerebrospinal fluid was found to be caused by leucocytes, the lymphocytes preponderating. In cases of purulent meningitis the polynuclear neutrophiles were in the majority.

Case 1. A. M., male, age 40, of Scotch descent, and good family history, contracted syphilis five years ago. I saw the patient first June 2, when he was suffering with numerous syphilitic ulcers on both legs. These improved rapidly under treatment, until the middle of July, when they were entirely healed. About July 1 he commenced to complain of excruciating pains, limited to the right side of the head, always worse at night, which refused to yield to ordinary remedies. Iodid of potash was given to the limit of toleration. August 1 I was sent for by friends of the patient, and found him semi-stupid, complaining of pain in the head and nausea, but he had not vomited. His condition becoming worse, he was sent to the hospital. His pupils were sluggish, reacting to light slowly, temperature elevated, pulse fast and weak, both eyes showing choked disc. Owing to the temperature, pulse, pain worse at night, extreme restlessness of an automatic character, stupidity, and extreme pain localized in the right temporal region, a diagnosis of syphilitic meningitis was made, with a probable gummatous growth in the region of the pain, at the same time conceding the possibility of tumor, which, owing to lack of focal symptoms, could not be localized.

On August 24, the patient having been without sleep or rest for four days, lumbar puncture was performed, and 25 ccm of fluid having an almost imperceptible cloudiness, were withdrawn; 12 ccm were given to Dr. Ohlmacher for bacteriologic examination. The fluid proved to be sterile, and cultures and animal inoculation gave negative results. The fluid that I retained showed fibrin shreds and some leucocytes, the majority being polynuclear. Fehlings solution gave an immediate test for sugar, throwing down a heavy red sediment. The bismuth test also gave positive results. There was 1-20 of one percent of albumin. Coverglass preparations failed to reveal the presence of any bacteria. There was no rise in pulse or temperature following the puncture. The patient almost immediately went off into a quiet sleep, the first for four days, and after awakening was much

brighter than he had been for three weeks. This amelioration continued for about a week, when all his untoward symptoms returned. From September 2 on the patient failed rapidly, was stupid and had convulsions. On the evening of September 6, the second puncture was performed, and 35 ccm of cloudy fluid containing flakes were withdrawn.

The operation seemed to diminish the amount of restlessness, but beyond this no effect was noticed. The amount of sugar in the fluid was considerable. By the centrifuge the amount of albumin was one-fourth of one percent. The sediment showed fibrin and some polynuclear leucocytes. Coverslip preparations failed to show bacteria. The patient died on the morning of September 9.

Autopsy on the head alone showed a thickening of the dura mater above, with some adhesions between dura and skull, particularly marked about the region where pain was so intense, and numerous points of adhesion between dura and brain. Section of the hardened brain showed a large tumor in each lobe of the cerebrum, springing from the lateral ventricles, and cavities in each lobe of the cerebellum, connected with each other but not with the fourth ventricle. This interesting case I hope to be able later to present to the society in detail.

Case 2. J. D., farmer, age 56, was injured in a runaway August 30. The pupils were sluggish. There were involuntary action of the bowels, stupor and delirium. The temperature was elevated, and the pulse fast. Through the kindness of Dr. C. B. Hunniston, I was permitted to make a puncture, but could not obtain a single drop of fluid. The needle was withdrawn and inserted twice, going in about  $6\frac{1}{2}$  cm, and I am quite positive that I was in the subarachnoid space. The patient died in three days, and no autopsy was obtained.

Case 3. J. H., age 35, fell down a flight of stairs, striking on a stone flagging, sometime during the night of September 10, and was not found until four o'clock on the morning of September 11. I saw the patient at 10 A. M. September 11, for Dr. House, at which time he was semi-conscious, with a pulse of 130, temperature 102.6°; the right arm and right side of the face were paralyzed, muscular movements in right leg were slow and weak, the tongue deviated to the right, the pupils were irregular and reacted sluggishly to light. The patient was continually making efforts to roll over to the right, and several times he succeeded in rolling himself out of bed. His condition being considered very serious, he was transferred to St. Clair Hospital, where a lumbar puncture was performed, and 10 ccm of bloody fluid withdrawn. This, after being allowed to stand six hours, showed a sediment composed of red blood corpuscles, great numbers of polynuclear leucocytes and considerable fibrin. There was a faint trace of sugar, and one percent of albumin.

Owing to the marked focal symptoms, the patient was trephined by Dr.

House over the right arm-center. Upon removing the button of bone, the dura was found tense and bulging. Upon incision, about a teacupful of bloody fluid similar in appearance to that obtained by puncture gushed out. No clot was found. Following the withdrawal of the fluid the pulse became much slower, and the patient's condition seemed better, but this was only temporary, for in a short time the pulse was up to 160 beats per minute. The patient died on the afternoon of September 12. Autopsy showed bloody fluid in both ventricles, a clot in the left lobe of the cerebrum, interrupting some of the fibers of the internal capsule, and a clot about the size of a hickory nut in the anterior portion of the right lobe of the cerebellum. There was also a great quantity of bloody fluid between the dura and the brain. It seems quite probable that the clot in the cerebellum was the cause of the tendency to roll over.

Case 4. J. F.; male, age 40, was injured September 14, by colliding with a wagon, and falling on his head. The patient was unconscious, with contracted pupils, stertorous breathing, a pulse of 120, and temperature of 101°. Through the kindness of Dr. J. E. Cook I was permitted to make puncture, drawing off 20 ccm of dark bloody fluid. On being allowed to stand six hours, the red corpuscles were thrown down, leaving the supernatant fluid distinctly cloudy. Microscopic examination of the sediment obtained by the centrifuge showed great numbers of red cells losing their hemoglobin, also numerous polynuclear neutrophiles, and some fibrin. Purdy's method showed 10 percent of albumin; the fluid also showed a trace of sugar.

The patient died September 17, and the postmortem examination was made 12 hours afterwards. The dura was so tightly adherent to the skull-cap, that in lifting, force sufficient to tear the dura was required. The dura was adherent to the brain an inch on either side of the longitudinal sinus throughout its entire extent; these adhesions were all recent. A clot about the size of a hand was found between the dura and the brain, on the left side, occupying the anterior and middle fossae. The under surface of the anterior lobe was considerably softened, and a deep fissure in the same locality seemed to warrant the belief that there was laceration of brain substance. The left lateral sinus was ruptured, and this seemed to be the source of most of the hemorrhage. The right lateral ventricle contained a large softened clot. There was no fracture of any portion of the skull.

Therapeutically, the result of the puncture in the last two cases was negative; in the first case, however, it seemed to me that the amount of benefit derived from the operation warranted its performance. In the first case it was possible to bar out tubercular meningitis and purulent meningitis. The large amount of sugar in the fluid made me feel certain that a growth of some kind would be found, in connection with any other condition that might be present. In cases 3 and 4 I felt sure of the presence of bloody

fluid in the ventricles, and owing to the dark bloody fluid in case 4, an intra-ventricular clot was suspected. However, one puncture in a case of this kind is not sufficient to warrant a positive diagnosis of bloody fluid in the ventricles, for the possibility of wounding a vessel while making the puncture must always be taken into consideration.

1151 Superior Street

### Stricture of the Esophagus

BY F. E. BUNTS, M. D.

*Professor of Principles of Surgery in the Medical Department of  
Western Reserve University*

**S**TRICTURE of the esophagus is one of the most frequent pathologic lesions of this organ. Inasmuch as the tendency of such a stricture, if left alone, is to progressively contract, just as we find in strictures elsewhere, the method of its relief becomes a most important problem for the surgeon to solve. The comfort and welfare, even the life of the patient, depend upon the recognition of the lesion and its proper treatment.

The congenital form of stricture is comparatively rare, and while in its simplest form it is amenable to treatment by dilatation, yet in that form in which the tube is completely occluded there is practically no cure, notwithstanding the various ingenious operations which have thus far been resorted to. Spasmodic stricture is essentially of nervous origin and is most common in women, and its true character is easily made out, if necessary, by an examination under an anesthetic. Those strictures resulting from the presence of cancerous, tubercular, or syphilitic growths or from pressure of tumors and other pathologic conditions outside the esophagus must be diagnosed by inspection, microscopic examinations, bougies and by the history of the case. Their final treatment is nearly always operative.

It is of cicatricial strictures that I wish chiefly to speak. These strictures are caused by wounds of various kinds, and more frequently by the swallowing of strong acids or alkalies. The pain caused by the caustic swallowed may at first be sufficient, when coupled with the lesion which it would naturally cause, to account for the temporary dysphagia, but later on when the pain has disappeared and yet the inability to swallow solid foods continues, the true nature of the trouble may possibly suggest itself to the patient or his friends. In those cases which have been neglected the progress is usually very rapid in the severer forms. The inability to swallow solid foods is soon followed by an equal inability to swallow the softer foods, such as gruels, and in a short time even water and milk will, with the greatest difficulty, find their way through the tightening grasp of the cicatrix. Up to this time the patient has managed by repeated and deliberate efforts at swallowing food and drinks to keep up a fair degree of nourishment, and may have even been able to attend to his ordinary occupation. Naturally, as his

*Read before the Cleveland Medical Society October 23, 1896*



power to swallow even fluids becomes more and more diminished, his strength gradually fails, and regurgitation of everything swallowed occurs, and the picture is soon that of one who is dying of starvation and thirst. Emaciation is rapidly progressive and unless surgical aid is obtained death soon ensues from exhaustion.

The diagnosis of these cases rests first upon the history. Ordinarily this is easily obtained, but when the patient is a small child it is frequently difficult to find out just what has been swallowed. Perhaps the most common cause of this class of strictures is lye. Almost every household uses lye for cleaning out sinks and drains and a small amount of it left in a cup may be swallowed by mistake. Next must be taken into consideration the symptoms; deglutition becomes progressively impaired until all or part of the food is vomited, and this persistent inability to swallow or retain food of any kind should call attention at once to the possibility of a stricture. The convincing test is, of course, the esophageal bougie, and if the other forms of stricture can be excluded and the bougie meets with obstruction in any part of its course, a cicatricial stenosis may be safely diagnosed.

The prognosis depends upon the extent of injury to the mucous membrane, and consequently the degree and rapidity of contraction. The rapidly contracting strictures are the ones most difficult to dilate and to keep dilated. The degree of stricture which permits the taking of liquids and semisolid foods is perfectly compatible with life and active business pursuits, and may never call for interference on the part of the surgeon, but the greatest number of cases pursue a most unfavorable course and terminate in death if not speedily relieved.

Before discussing the treatment of these cases I wish briefly to relate the history of three cases which came under my care during the past year.

Case 1.—A child two years old had been at the "Fresh Air Camp" for malnutrition and persistent vomiting. When brought to my dispensary it was greatly emaciated, fretful and anxious-looking. The mother said it had not been able to retain anything for two or three days, even a teaspoonful of water being regurgitated in a few moments. I tested the child myself and found the mother's statement to be true; it was constantly crying for water but could not retain the slightest amount. Suspecting a stricture and finding upon questioning the mother that the child had swallowed some lye, though a very small amount, as she declared, I endeavored to pass a bougie, but, meeting with an obstruction, was compelled to use a smaller one, a No. 8 French. Immediately after passing this bougie I handed the child a glass of water, and before we could get it away it had ravenously swallowed the entire contents of the glass and showed no inclination whatever to vomit. The child was brought for treatment at irregular intervals for a number of months. The progress was, however, very unsatisfactory, inasmuch as the mother would not bring it back except as the stenosis became too great for it

to swallow water. At first the child regained its health and flesh with surprising rapidity, but later, as the treatments became more and more irregular, it began to decline, and the stricture became more and more difficult to overcome. The last time I saw it I was unable to insert a No. 8 bougie, and its condition was such that I could hardly expect it to live much longer.

Case II.—This case was referred to me by Dr. Ashmun, who saw him some time after the accident. When first seen by me he was in the hospital, where he had gone for an operation. He was greatly emaciated, very weak, scarcely able to stand, and unable to swallow even water, so that we were obliged to give him nourishment by the rectum. I soon found that I had no bougies small enough to pass the stricture, and, as he urgently requested an operation, saying that he could not and would not live any longer in that condition, I intended to perform a gastrostomy, but succeeding in procuring a very small whale-bone probe I managed to pass it, after which he could manage, by taking a very small amount of liquid at a time, to retain it. Following up my advantage, I had a series of double-bulb bougies made, and soon had his stricture dilated to a No. 12. He then became impatient and left the hospital, able, however, to drink milk. I did not see anything further of him for nearly two weeks, when I was sent for and found him again unable to swallow even water. It was with the greatest difficulty and perseverance that I passed my smallest probe and afterwards dilated the stricture gradually to a No. 22. Then he passed out of my care, retaining two of my bougies which he had learned to pass himself. He could swallow semi-solid foods and even eat meat, but only in small quantities finely chewed and washed down with water or milk. He had grown fat and strong and weighed more than ever before in his life, and was very content to keep along in the way he then was. I am satisfied that I would have dilated to a much higher number, but he thought he was well enough and could not spare the time.

Case III.—This was a child two and one-half years old, who had accidentally swallowed less than a teaspoonful of red-seal lye four weeks before I saw him. Following the swallowing of the lye he could not eat anything for three days; then he began to eat and nothing serious was suspected for three weeks, at which time he could only swallow milk. This condition persisted up to the date of his first visit to my office. Attempting to pass a large bougie I was unsuccessful, but the small No. 6 passed readily and I was able to dilate it gradually at subsequent attempts up to No. 28 French. I then supplied the parents with a rectal tube of this size and they pass it at intervals sufficient to maintain patency. The child gained rapidly after the first dilatation.

I had thought that the double-bulb bougies which I had constructed, and which I show you tonight, were original, but I find on further reference to the subject that Trousseau had devised a very similar bougie, his having three or four bulbs instead of two. In strictures near the cardiac orifice,

as was the case for which I first designed them, I believe two bulbs have an advantage, since there would be no danger of injuring the stomach by the projecting end. I have had the bulb made so that the distal one or one which first engages the stricture is just one size smaller than the next one. Thus, if one bougie contains bulbs 10 and 11, the next would have 11 and 12, the next 12 and 13. This insures the passage of the first bulb always and renders the passage of the second almost certain.

I present these cases and this simple means of treatment believing that the early adoption of this method by graduated double-bulb bougies will, in a great many cases, render the performance of gastrostomy and retrograde dilatation unnecessary even in some of the most serious cases, such as that related as Case II.

380 Pearl Street

## The Value of the Thermo-Mineral Cure in the Treatment of Syphilis

WILLIAM THOMAS CORLETT, M. D., L. R. C. P., LONDON

*Professor of Dermatology, Syphilology and Genito-Urinary Diseases in the Medical Department of Western Reserve University*

IN response to a letter of inquiry from Prof. Assaky, of Paris, relating to the treatment of Syphilis by the Thermo-Mineral Method, I have prepared the following answers, which embody in brief the results of my investigations in the treatment of this disorder. Professor Assaky's question is given in each instance.

### I.

1. Is this cure useful, indispensable, or does it not seem insufficient?

As syphilis tends to become eliminated from the system the object of treatment is to hasten this elimination, to destroy or lessen the virulence of the virus *in situ*, and to heal existing lesions. Heat applied in the form of baths (water, steam, etc.) has a mild influence in augmenting elimination as well as of allaying existing lesions.

2. Is it shown in all the different forms of syphilis?

This holds good in the various forms and phases of the disease.

3. Is it to be applied from the commencement, or simply in advanced syphilis?

The sooner the better.

4. Does it make part of the preventive treatment, or is it to be employed against present manifestations only?

Answered in the foregoing.

5. Do there exist any particular manifestations justifying this treatment?

There are cases, especially among the dwellers of large cities, in which mercury and the iodine preparations fail to produce the desired effect. These

are usually cases of long standing, at least one year, and are especially benefited by the thermo-mineral cure. This latter incidentally includes fresh air, sunlight, exercise and drinking hot water, which are equally important with bathing.

6. Has it an action on the tardy localization of the nervous system?

The more rapidly syphilis is eliminated from the system, the less liability there is to late manifestations and lesions of the nervous system.

7. Has it not any counter-indications derived from the nature of syphilitic accidents?

Judiciously employed, I think of none.

## II.

1. What are the advantages of the mixed thermal and mercurial treatment?

Aside from the advantages mentioned, by stimulating the organs of elimination, a greater quantity of mercury and the iodine-compounds may be given without producing the disagreeable effects of these drugs. I do not believe their retention in the tissues for any length of time is necessary to obtain the best results.

2. Must the mercurial treatment be prescribed during the mixed treatment alone, or associated with the iodide of potassium? Are there any distinctions to be made on this subject?

Mercury seems efficient in destroying the virus of syphilis, as well as in causing the earlier lesions of the disease to disappear, while the iodide of potassium, by stimulating the absorbents, heals the late manifestations without especially preventing their return.

3. How (by which therapeutic means) can the patient be mercurialized during the thermal cure? In what limits? The doses to be employed in the absence of the syphilitic symptoms.

The patient may be mercurialized by any of the usual methods, such as inunction, deep injections, fumigating, or by the mouth. It should not, however, exceed a slight tenderness of the gums. The dose varies according to the nature of the case, the length of time the disease has run, together with the severity of the preceding symptoms.

4. Does the thermal treatment confer any immunity against hydrargyrism?

It does.

## III.

1. Do the thermal and the sulphurous waters particularly employed, with the exception of the specific ones, possess in present or recent cases of syphilis a constant injurious effect? Are they equally contra-indicated immediately after the mercurial cure?

I am not aware of any injurious effect, neither have I observed any after a course of mercurial treatment.

2. Is the treatment called "*traitement d'Epreuve*" to be absolutely condemned?

There are very exceptional cases in which the "*traitement d'Epreuve*" may be employed.

#### IV.

1. To which variety do the waters which you describe belong?

Plain water, or water charged with carbonic acid, while in some instances the sulphur waters are preferable.

2. Do you order waters of different composition in the different forms or the different stages of syphilis?

No.

3. What importance must be given to thermality (high thermality)?

A high thermality favors elimination.

4. Under what form do you administer thermal medication?

Plain water daily, and a Turkish bath once a week.

5. What is the length of the treatment?

It varies greatly; as a rule from one to four years.

6. Is one season a year sufficient in latent syphilis, or actual syphilis?

It is not.

7. How many consecutive seasons in all do you prescribe in latent syphilis or in actual syphilis?

See No. 5.

From the foregoing it will appear that my views are in favor of the thermo-mineral treatment for syphilis, but not as usually followed at health resorts. The subject has seemed to me of sufficient importance to warrant considerable time and outlay during the past few years in visiting many of the springs of Europe most noted in the treatment of syphilis, as well as a few in Mexico and in this country. The duration of time the vast majority of patients can give to this treatment at resorts is far too short to do more than to relieve present symptoms. A few weeks to one or two months is the average time given to a "cure," which, even if followed year after year until the disease shows no tendency to return, is not, in my experience, the best method of treating syphilis. Few, however, are able to make yearly trips, and the majority must content themselves with the belief, unfortunately too often strengthened by the assurance of the medical attendant, that the disease is thoroughly "boiled out of them." Again, too much stress is given to the "cure" properties of the waters, thereby often neglecting the essentials of a successful treatment, viz., the administration of mercury and iodine. For general use, pure water, free from organic substances, or carbonated water is the best.

In certain cases sulphur water may be advantageously employed. The necessary appliances for conducting a systematic thermo-mineral treatment should be found in every well regulated hospital where syphilis is treated.

558 Euclid Avenue

## Report of a Case of Compound Fracture of the Leg

BY JOSEPH F. HOBSON, M. D.

*Professor of Minor and Casualty Surgery in the Cleveland College of Physicians and Surgeons*

JOHN SEULING, age 44 years, teamster by occupation, of large frame and good muscular development, as far as could be learned was temperate in his habits. September 3, while at work with his horses, he was kicked on the right leg by one of them, sustaining a compound fracture of both bones. He was taken to his home and a doctor(?) summoned. The leg was put up in Plaster of Paris, with a trap at the point of fracture; apparently no effort was made to purify the site of the wound; the hemorrhage was uncontrolled and the bones not put in apposition. Morphin was administered in large doses, and whisky in ample quantities to both patient and attendants. Within two days the unfortunate individual was wildly delirious, with a weak, rapid pulse and a temperature of 104 degrees.

In this condition he was brought to the Cleveland General Hospital. An examination of the injured leg revealed an intense swelling and inflammation of the entire extremity from the knee to the toes; there was constant discharge of bloody pus, and the lower fragment of the tibia was still protruding through the opening.

I was very reluctant to admit such a patient to the hospital ward, as there was danger of infecting other cases, and it looked as though he would soon succumb to septic infection; he was, however, admitted to a ward-room isolated from all other surgical cases. Before he was placed in bed the plaster cast was removed, the leg shaved, the opening amplified, bleeding vessels tied, foreign bodies removed, and the bones put in as good apposition as was possible under the circumstances. The entire leg was thoroughly irrigated with bichlorid solution, the cavity packed with gauze, and the extremity enveloped in bichlorid fomentations. Thin coaptation splints were applied laterally, and the entire leg placed in a Volkman trough. Owing to the delirious condition of the patient, the leg was in constant motion. The mercurial fomentations were alternated with irrigations of the same antiseptic. The patient was supported with food in liquid form and of the most easily assimilable character. Medicines as indicated by the symptoms from day to day were employed.

At the end of two weeks the purulent discharge was still profuse and the delirium severe.

Owing to the constant movements of the patient any union of the bones was practically impossible; at this period the man was anesthetized and the fractured tibia was wired by a good stout silver wire, the leg dressed as before and immobilized with a plaster cast.

This was done by one of the hospital surgeons, in whose care the case

*Read before the Union Medical Association of Northeastern Ohio, at Canton, Nov. 15, 1896*

was placed during my temporary absence from the city. During the operation a slight abrasion of the skin on the right hand of the operator was followed by a sharp cellulitis lasting almost two weeks.

The delirium after this operation was still unabated; during a momentary absence of the attendant he sprang from the bed and struck the floor with the injured leg, snapped the wire holding the bones together, and did considerable damage to the soft parts. This condition continued for two weeks longer, when it was found that the entire lower portion of the tibia was necrosed; signs of exhaustion from the prolonged suppuration were now very apparent. The mental condition improved somewhat during this period; he was perfectly rational the greater part of the day. It was now plainly impossible to restore the leg to any degree of usefulness, even if the man's life could be saved. Amputation was proposed and readily accepted. On the 9th of October, a little over one month after the injury, the leg was amputated just above the knee-joint, this having become involved in the destructive process.

The ordinary circular amputation was made, the vessels were in good condition, but the muscles and other tissues showed very plainly the effect of the long-continued inflammation.

The operation seemed to aggravate the mental condition; only for a few hours at a time during the next few weeks was he rational. The restlessness returned, and, unless in a strait-jacket, the dressings of the stump were torn off, thus preventing the healing of the wound. For many days after the operation his life was in great danger, transfusion of normal saline solution being resorted to at one or more intervals. He was freely stimulated with brandy. Beef-juice and milk were given as often and in as large quantities as he could tolerate. Hypodermic injections of strychnin 1-30 grain every two hours aided very greatly in keeping up a flagging heart. Hyoscin in 1-60th grain doses served to control in some degree the delirium. Malt with the hypophosphites supplemented the nutritious food given him. At the present time the patient is in a very satisfactory condition; his mind is entirely clear, appetite good and sleep undisturbed. The stump is almost closed, the greater part of it closing by granulation. In about one week he will be discharged from the hospital, and within two months he will, no doubt, be able to wear an artificial leg.

I do not present this case for the purpose of exploiting any new method of treating compound fractures, but simply to emphasize the importance of thoroughness and care in carrying out the well-recognized details of the primary dressing. This case has been instructive, from the fact that it demonstrates the progress and termination of compound fractures that have not been treated as every progressive physician knows they should be treated. Not many years ago these cases were, unhappily for all, far too common; at the present time they are, be it said to the credit of an enlightened profession, very uncommon.

The treatment of compound fractures is determined very largely by the extent of the external wound, and the circumstances under which the injury has been inflicted. In any case in which the wound has been produced by violence from within and the opening small, and without much hemorrhage, interference with finger or probe is wholly unnecessary and may do harm. The surrounding parts should be rendered clean by shaving, scrubbing, and the free use of antiseptic solutions, and the wound closed by iodoform gauze and iodoform collodion. By so doing it is possible to convert a compound into a simple fracture, the object sought for in all cases. On the other hand when the injury has been produced by a crushing force from without as well as from within, when there is a comminution of the bones, when foreign substances have been driven into the wound, when large vessels have been severed, very much more energetic and heroic treatment is demanded. In this event, if in an extremity, and an attempt is made to save the limb, careful exploration of the wound is imperative; all foreign particles must be removed, bleeding vessels tied, divided tendons and nerves brought together, torn and lacerated shreds of tissue cut away, small particles of bone removed, drainage established at the most dependent point, and the cavity most thoroughly irrigated with bichlorid solution, and the part immobilized with a stiff bandage.

A good opportunity will present itself for a perfect reduction of the fracture before the external wound is closed with sutures.

The extent of the laceration of the soft parts will determine the kind of dressing to be applied.

*429 Prospect Street*

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## Tubercular Caries of the Ribs

BY H. BLANKENHORN, M. D., OF ORRVILLE, O.

A. N., a man of good habits and good ancestry, never had a serious sickness, but had an injury of the chest when 17 years of age, having been kicked on the front of the chest by a horse at that time. He was laid up for a week, suffering a great deal of pain, and spit up some blood, but fully recovered and was a strong and hard-working man up to the latter part of September, 1895, at which time he had an attack of typhoid-fever, confining him to the house for a few months. He was at this time about 45 years of age. He made, to all appearance, a good recovery in the usual time, but soon after being able to be about he noticed a slight swelling, accompanied with pain, immediately below the right breast, extending in the direction of the ribs. It was at first a hard tender enlargement apparently adherent to the rib, somewhat elongated; it became intensely painful, and in a few weeks began to become red in the center and bulge out to a fluctu-

*Read before the Union Medical Association of Northeastern Ohio, at Canton, November 15, 1896*



ating point. I opened it at this point; there was a discharge of a milky character, not profuse but continuous, forming a permanent sinus. There was no letting up of the pain nor subsidence of the swelling. This discharge continued, becoming more profuse, having at times a gritty granular substance, showing plainly its source and character. Caries of the sixth rib, no doubt of a tubercular character, was the diagnosis, and operative interference was advised. The case was referred to Dr. J. H. Stoll, of Wooster, who concurred in the opinion as expressed above, both as to diagnosis and management.

Operation was deferred until early in May following, at which time I cut down upon the rib freely, removed all the pathologic soft tissues and removed with bone-forceps the anterior part of the rib over the seat of the disease, curetted thoroughly and packed with gauze. In due time this healed up nicely, but in a very short time the two adjacent ribs above and below the previous seat of trouble began to be involved; these ribs also began to pain him and showed evidences of active inflammation, and in due time there again followed sinuses, fever, emaciation and extreme suffering.

In the following September I again operated on the two diseased ribs; they again in due time healed up, and again promptly followed the involvement of a lower rib. In December following I sent the patient to Lakeside Hospital in Cleveland, at which time Dr. Allen took charge of the case and made a very thorough operation, retaining the patient in the hospital for 30 days, when he was sent home somewhat improved, only to develop trouble more active than ever. He became entirely helpless, suffered great pain and was very much reduced in weight. Several ribs at this time were involved and kept constantly discharging through various sinuses; other structures in the lower part of the thorax began to take on trouble; the diaphragm became endangered and the outlook was anything but promising. It became obvious that operative interference was unsatisfactory and that some other means must be resorted to. It occurred to me that in iodoform we had a therapeutic agent from which we could realize some good in this case, but to get it in contact with the diseased tissues through the tortuous sinuses was the problem. I injected for a time an ethereal solution of iodoform, and, although it caused considerable pain, the results were encouraging. I finally used a 10% glycerin emulsion of iodoform and forced it into the sinuses so as to get it into every crevice, with the most flattering results. Whenever a new sinus opened I promptly injected the glycerin emulsion, and by the latter part of August all were entirely closed, there being no more pain nor any disturbance at this date and to all appearances the progress of the disease is entirely overcome. The patient has regained his usual weight, is feeling quite well, and is very grateful for the relief obtained.

I wish to call this case to your notice, principally because of the results of the persistent use of iodoform emulsion with glycerin, after repeated operative interference had proved unsatisfactory. It may be said that it is as yet too early to say that the trouble is entirely overcome, for a patient "once tuberculous, is always tuberculous;" if so we will feel gratified with the subsiding of the local trouble as it is at this date.

Again, it may be argued that the bacilli of Eberth were the cause of the trouble as a sequel of the recent fever, and not the bacillus tuberculosis; to my knowledge no microscopic examination was made at any time, but all who saw the case expressed the opinion that the trouble was no doubt tuberculous. This opinion is also strengthened by the effect the iodoform had upon the disease.

# Cleveland Journal of Medicine

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## EDITORIAL

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### The Journal

WITH the present number the CLEVELAND JOURNAL OF MEDICINE completes its first year of life. Its aim has been to represent fully the work of the medical profession of Cleveland and its surrounding territory. We have tried to hold the mirror up to nature, rather than to New York and London Journals. The excellent work done by the Cleveland Medical Society, by the Union Medical Association of Northeastern Ohio, and by other societies of this part of the State should be made generally available. Our motto is: "The greatest good to the greatest number." The experience of the past year has shown that success may be won by the pursuit of a broad policy, and we feel justified in reducing our subscription price to \$1.00 when paid in advance. This is substantially in accord with the price of the Eastern weekly journals, whose subscription price is \$5.00. They are enabled to make that rate because their circulation permits them to do business on a

large scale, and the ever-widening field of the JOURNAL gives us the opportunity to make our price uniform with theirs. We feel that this reduction will increase the value of the JOURNAL to the profession at large, and be of very real assistance to the scientific work of all the societies within our sphere of influence.

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IN a very interesting paper in the *Canadian Practitioner* for November, Dr. Edmund E. King presents a careful report of a case of skin, hair and nail lesions produced by the "X" rays. The patient was a man engaged in giving "X" ray exhibitions, and during May he was exposed to the rays two hours a day. During June and July he averaged six hours a day exposure, sometimes the time being ten hours of constant contact. During this time he habitually stood with his right side toward the Crooke's tube. In July his right hand swelled considerably, and large blisters raised on the back. Picric acid allayed the symptoms, but for a month he did not exhibit. He began again the last of August, and now stood with his left side to the apparatus. After two weeks of constant work his lips swelled decidedly, as also did the left cheek and hand. The skin was discolored, tender, and ached like a severe sunburn. In ten days blisters appeared on the hand and the finger nails began to shed. His eyelids were edematous and he had conjunctivitis, worse in the left eye. The face was very erythematous and painful, but did not blister. Contact of the rays with the skin was so painful that he was forced to discontinue his exhibitions. At the time of report the skin on the hands was unusually smooth, infiltrated, congested, and free from hairs, and the nails were exfoliating. The left side of the face showed entire absence of hair over the temple and behind the ear, and the eyebrow was nearly gone. The left side of the moustache was almost gone, and also the whiskers on the left cheek. A number of photographs illustrate the condition clearly. This is the first well-authenticated and carefully reported case of injury from the "X" rays, but it is to be noted that the exposure was excessive. Injury from the amount of exposure necessary for clinical purposes has thus far not been noted by any competent observer. It would, however, be worthy of remark if no subjects are discovered who suffer by reason of idiosyncrasy from short contact with the rays. Surgeons and others using the rays should bear this case carefully in mind. The theoretic interest of this action of the rays is even greater than the practical.

THE daily papers have given us lately accounts of people congenitally blind who have been able to see by the action of the X-rays. These stories have their origin in a very hazy knowledge of the mechanism of seeing. It is quite possible that the X-rays may stimulate the optic nerve fibers so as to produce a sensation of light. It is easy to do the same thing by mechanic irritation, or an electric current; this does not restore sight to the patient, nor does it warrant lurid headlines. People who have become blind in maturer years may have vivid hallucinations and see flashes of light as a purely subjective matter. Neither is sight restored in these cases. The idea that blind people may be made to see is suggested by the fact that deaf people may be made to hear, by bone conduction. The latter is only possible when not only the auditory nerve but the internal ear as well are intact in case of middle-ear disease. An analogous case is that of blindness from cataract, or disease of the transparent media of the eye, with a good retina and optic nerve. In such cases it is conceivable that the X-rays might penetrate the opacities and affect the retina. It has not, however, been proved that they do affect the retina of either blind people or people with normal vision. If they do, this would only enable the blind to see the Crooke's tube and objects between them and it, which would be very far from giving them normal vision. The green light of a Crooke's tube is due to ordinary light vibrations, not to the X-rays at all. Until we can put a fluorescent screen into our patient's head it is not probable that this alleged miracle will be put on a working basis; meanwhile it is to be hoped that the army of blind unfortunates will not be lured by charlatans into a delusive hope of cure as a result of the ordinary newspaper story of commerce.

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THE following paragraph in the *Medical Record* of November 14 is a brief summary of a recent editorial in the *Lancet-Clinic*:

CLEVELAND MEDICAL SOCIETY.—It appears that an Ohio man was elected as a member of the judicial council of the American Medical Association at its last meeting, who was objected to by the Ohio member of the nominating committee. In his official capacity the gentleman elected seems to have prevented the recognition of delegates from the Cleveland Medical Society, and thus returned the compliment. Now the members of the Cleveland Medical Society have agreed among themselves to keep away from the next meeting of the American Association. It is said that the Ohio State Society approves of the Cleveland Society's action.

The above remarks are interesting as an item of news. They share one quality in common with the bulk of the news items of the present day.

They are not so. The members of the Cleveland Medical Society are not whining in a corner. It is their intention, on the contrary, to have at Philadelphia a large and influential delegation, prepared to take an active part in the scientific proceedings of the Association, and to secure at least a fair hearing for a Society in full accord ethically with the letter and spirit of the Code of the American Medical Association.

In a nut-shell, the situation is as follows: The Cleveland Medical Society, innocent of any wrong-doing, was without hearing suspended from affiliation with the Association in 1894, at the behest of one of the latter organization's politicians, who acted in the dual capacity of prosecutor and jury, and to further the personal interests of said politician. Along with sentence of suspension the Association specifically ordered its treasurer to refund all dues paid at the 1894 meeting by the Cleveland men present. The dues were not refunded, but on the contrary, other members of the Cleveland Medical Society were solicited to become members of the Association. In the same year the Cleveland Society was refused affiliation with the Ohio State Medical Society largely because of these charges. The following winter the Cleveland Society, in a spirit of honorable compromise, made a change in its constitution removing a clause which was technically objectionable to the State Society. As a result, at the 1896 meeting of the Ohio Society, it was received into affiliation with only one dissenting voice in more than 400 present, and that vote from the politician before mentioned. The 1896 meeting of the American Association saw fit, however, to renew the suspension of the Cleveland Society, and again ordered all dues of the local men refunded. Again the dues were retained by the Association, and Cleveland Society members are even now being solicited to join the Association. For two years the American Association has suspended Cleveland men from its membership, and has simultaneously received and retained their membership fees!

An interesting and pertinent fact of recent occurrence should also be recorded here. The Secretary of the Cleveland Society has for more than a year been endeavoring to secure from the Association a copy of the charges against the local Society. Thus far in the difficulty, in spite of two years' suspension, the Association has not deigned to allow the Cleveland Medical Society to see a copy of the charges on which it was suspended. Two letters from our Secretary recently failed even to elicit a reply from the Association's Secretary. A communication to the President, however, spurred the Secretary of the Association to write that he had no copy of the charges, and never had had, but that he would write the Ohio member of the Judicial Council, who brought the charges, for a copy. Some weeks have passed, and no charges are yet received. Perhaps in time for the Philadelphia meeting, the Association will deign to allow the local Society an opportunity to inspect the charges upon which it has been for two years suspended from all privileges.

The action of the State Society last year was a complete disclaimer of the deeds of the Ohio member of the Judicial Council.

We have no quarrel with the American Medical Association. We simply regard the inflammable gentleman aforesaid as a vermiform appendix on its body politic. If an acute attack of inflammation on his part should threaten to disrupt the organization, we would recommend removal of the appendix. We would be glad to remain in a thus regenerated American Association. If they were to invite us to step out the loss would, we think, be mutual, but the study of the science of medicine is still open to us. There is no danger, however, of our staying away, until we are invited to do so by the unmistakable voice of the Association itself, which has not yet, we believe, been heard on this question.

[An editorial in the *Columbus Medical Journal* which we reprint elsewhere, gives a very fair statement of the matter.]

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IT is pleasing to note that the revival of business is not at present the only promising sign of the times. Especially to medical pessimists we wish to point out two facts which show that good work does ultimately tell. This JOURNAL has persistently advocated the appointing of a staff of consulting physicians and surgeons at the State Hospital in Newburg. In incorporating this suggestion as a recommendation in his last annual report, Dr. Eyman has made a move alike creditable to him and promising for the good of the institution. It is to be hoped that it will be followed by appropriate action on the part of the trustees.

The second matter is one of equal, if not greater importance, to the public at large. The Cleveland Medical Society, last spring, held a meeting devoted to the hygiene and arrangements of our public schools. At that meeting, and editorially in this JOURNAL many abuses were pointed out which had gradually come about from the overcrowding, due to the increase in our population. We notice with great pleasure that additional buildings are to be erected, so that the pernicious system of double sessions may be abolished. With the best intentions in the world a Board of Education cannot keep the schools in proper condition without help from the medical profession. A Board of Medical Advisers should constantly inspect the school buildings, and possibly also the scholars, so that the children's bodies may keep pace with their minds in a normal and even development. The action of the School Board is a long step in the right direction.

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THE local papers recently announced that Dr. D. R. Jennings, dentist, is preparing to bring further charges against the Cleveland Medical Society before the coming meeting of the American Medical Association. Why a dentist should wish to involve himself in an assault on the medical profession is beyond comprehension.

OFFICIAL PROCEEDINGS  
OF THE  
**Cleveland Medical Society**

REGULAR MEETING OCTOBER 23, 1896

*The President, DR. COOK, in the chair*

The chair appointed a Committee, consisting of Drs. A. R. Baker, P. H. Sawyer and G. C. Ashmun, to draft suitable resolutions on the death of members recently deceased.

**Reports of Cases and Exhibition of Specimens**

DR. M. ROSENWASSER

*Epithelioma of the Cervix*

I have here a specimen of the uterus and appendages removed yesterday for epithelioma of the cervix. I present the specimen, not so much for the epithelioma of the uterus, as on account of what I found in connection with it. This woman was referred to me by the kindness of Dr. Hanson. She is 35 years old, married 14 years, has had six children. Never had any miscarriages. Menstruated freely and regularly every three or four weeks for seven days; no pain. About four months ago she missed her menses for six weeks; then had a continued flow with clots for five weeks; since then she has had simply a watery discharge. When seen by me the discharge had a decided odor. Dr. Hanson tells me that on account of constitutional syphilis in the children he had suspected the same trouble in the mother. He had administered iodids without any effect. I found the cervix with the characteristic circumference eversion of epithelioma; the surface of the lower half of the cervix was eroded, granular, partly covered with a slough. One could break off small pieces and cause the cervix to bleed very easily. It is rare to see these cases in the early stage. Usually we see them after the cancer has extended into the vaginal vault or into the broad ligament.

I advised this woman to have the uterus removed as soon as possible. The examination at the time disclosed the uterus retroverted, but no other complications. I felt no tumor. This operation was made by the abdomino-vaginal method. I first loosened the tissues around the cervix, separating the bladder in front and opening into the recto-vaginal pouch behind the uterine arteries, then made the abdominal section and secured the ovarian arteries. The left ovary was about the size of a flattened orange, and it felt as though it contained a mass of fat. The right ovary was enlarged by a number of follicular cysts. The specimen was sent to Dr. Ohlmacher for examination. On opening the ovary, there was found a mass of fat, with here and there a little hair. There were numerous epithelial cells, proving it to be a dermoid cyst. It may seem strange that the ovarian tumor could not be felt on bimanual examination, but when we remember that it was as soft as butter, we can understand how easily it would escape observation. It is not

usual to find dermoid cysts free. They generally produce sufficient irritation to cause adhesions. This woman suffered no pain, except during two or three days before operation, when she had some backache.

**DR. O. B. CAMPBELL:** I would like to ask Dr. Rosenwasser if it is not rare to have that much disease of the uterus and also disease of the ovaries without any pain. I would also like to ask him if it is not rare to have that much disease of the neck of the uterus and also both ovaries and not have any trouble in the fundus of the uterus. The uterus in the specimen is entirely healthy except the cervix. Is this not a rare specimen?

**DR. ROSENWASSER:** Epithelioma of the vaginal portion is not attended with any pain. Pain as a characteristic of cancer exists only when the cancer has extended into the body of the uterus or into the broad ligament. The ovary which contained the dermoid cyst might have caused pain if it had been bound down by adhesions. This ovary gives no evidence of inflammation about it, and consequently there is no reason why there should have been any pain. One would most reasonably expect pain in the follicular ovary on the other side. The specimen is rare as a dermoid cyst containing pure fat. Usually we find a large bunch of hair, bone, teeth, etc. This is pure fat, soluble in ether, chloroform and alcohol.

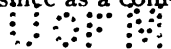
The question might be suggested why I did not limit the operation to amputation of the cervix. We cannot tell how far up into the cervical canal the cancer has extended; nor how far into the lymph vessels. Furthermore, it is not now considered rational to amputate a cervix for cancer any more than it is to amputate a portion of the breast for cancer. The safest course is to leave no portion of the gland or adnexa behind. For this reason I made the combined operation. The patient, 36 hours after the operation, is doing well.

#### DR. C. F. HOOVER

##### *Aortic Aneurism*

I have shown two men here with aneurism of aorta, and both of them with aneurisms in the same position, the descending portion of the arch of the aorta. This specimen is from one of them. This man was an Englishman, a prize-fighter and a soldier. When I first saw him he suffered only from pain over the precordial region. It is astonishing to see what a large aneurismal sac there may be without any external evidence whatever. The only signs the man showed were dullness at the apex of the left lung without any râle. He also had a dilatation of the pupil on the left side, and the left vocal chord did not move quite as readily as the right. The necropsy was made a short time after his death. You see a large aneurism of the descending portion of the arch of the aorta.

The other man is still living whom I showed here a year ago. He had only accentuation of the second aortic sound, with a pulse of short duration and severe pain in the precordial region and under the left shoulder. After I had him under observation for a month, I found he had an extensive herpetic eruption on his left supra and infra-clavicular region and entire arm. That I regard as additional evidence of aneurism. I saw him later and found that he had a positive venous pulse when he lay down, from pressure of the aneurismal sac on the *vena cava*. The man remained at the hospital for about two months. He has been working ever since as a common laborer with very little pain.





These two cases show very nicely how the confined aneurism is the one that causes the severe pain. I had another man at the polyclinic who had an enormous pulsating aneurism away down to about the eighth rib in the anterior axillary line, and the man stated that of his own knowledge, it had been pulsating for seven years, and he had no pain. When aneurisms are easy to find they cause little trouble.

### Program

DR. B. E. SAGER

*Report of Three Cases of Diphtheria Treated by Antitoxin*

### Discussion

DR. G. S. SMITH: Dr. W. H. Welch, in the Bulletin of the Johns Hopkins Hospital, says that the use of antitoxin has diminished the percentage of nephritis, although it is questionable if it has lessened the number of those showing albuminuria; in fact, the albuminuria has seemed to be at times increased. Heart failure has not been reduced at all, but fewer patients die of it. According to some authorities post-diphtheritic paralysis is even more common when the antitoxin has been used, than when former methods have been employed. If true, it is probably due to the survival of a larger number of cases.

DR. SAGER, in closing: The statistics of Jefferson Medical College showed the following death rates: If administered the first day, 1 percent or two percent of deaths; second day, 3 percent to 5 percent; third day, 8 percent. If administered beyond the fifth or sixth day the death rate is increased in a greater ratio.

In regard to heart failure, there was a case in which Dr. Ohlmacher was seen in consultation. It was of malignant type, and the sanitary condition was such that it was very depressing. In this particular case there was a tendency to heart failure. I think that if it had not been for the heart stimulants, the large doses of strychnin that we gave almost from the first, and the liquor, the case would have died. In a great many of these cases heart failure is attributed to the administration of antitoxin, while it is really from other causes.

DR. F. E. BUNTS

*Report of Case of Stricture of the Esophagus*

This paper appears in full on page 555 of this number of THE JOURNAL

DR. H. T. CLAPP: I would like to inquire of Dr. Bunts if there was only one stricture in these cases, and what that was; and whether in dilating them they ever bled, and if they did, what he gave.

DR. BUNTS: In the first child the obstruction seemed to be, as far as I could judge from measurement, about three inches from the cardiac orifice. In the second there were three strictures; one opposite the cricoid cartilage, and the other two apparently about two inches apart, and very close to the cardiac orifice. The other one was not more than half way down the esophagus, possibly near the cricoid cartilage. There was no bleeding in the first and third cases, but in the second there was very slight bleeding, although, as I increased the size only one grade French at each dilatation, the bleeding was so slight I had no trouble with it. I think you would not be likely to get any bleeding unless there were soft tubercular or syphilitic structures.

## REGULAR MEETING NOVEMBER 13, 1896

*The President, DR. COOK, in the Chair*

Meeting called to order at 8 P. M.

The following gentlemen were elected to membership in the Society: W. B. Shackleton, Graduate of Wooster Medical College, 1895; Resident Membership. Dr. R. D. Gibson, of Youngstown, Graduate of the Cleveland Medical College, 1880.

DR. BAKER, as Chairman of the Biographic Committee, made the following report:

## DR. PETER IGNATIUS SPENZER

DR. PETER IGNATIUS SPENZER, the son of a shepherd, was born in the little hamlet of Aschhausen, romantically situated in the valley of the Jagst, and nestled in among the forehills of the Black Forest Mountains, in the Kingdom of Wuerttemberg, Germany, on the sixth of August, 1837. He was left an orphan at an early age. When sixteen years of age, like a true Schwabian, his independent character rebelled against an unjust and severe guardian who insisted that he become a cobbler, and he departed friendless and almost penniless for America.

Stopping first at Hull, England, he sailed directly for New Jersey, where he remained for one year, working on a farm and busying himself with acquiring the English language. He then began the study of pharmacy with Fleming Brothers, of Pittsburg, Pa. Removing to Cleveland, Ohio, in 1856, he served in succession in the pharmacies of Parker and Butler, Benton and Dunham, Dr. C. O. Benton and Hugo Hentsch, the last of which he managed. Entering the army with the First Ohio Light Artillery, he was soon detached and appointed Hospital Steward at Louisville, Ky., by Col., now General Barnett, which position he held for one year, being discharged on account of failing health. Returning to Cleveland he formed a partnership with Louis Smithnight, under the firm name of Smithnight & Spenser, which was dissolved in 1869, when he opened the first pharmacy on Central Avenue, then Garden Street. Dr. Spenser took up the study of medicine in 1870, and was graduated in 1873 from the Medical Department of the University of Wooster, at Cleveland, since which time he has continued in its active practice. He always took a deep interest in scientific pharmacy, having been a member of the American Pharmaceutical Association since 1871, and of the Ohio State Pharmaceutical Association from its foundation. He was a chief factor in the formation of the Cleveland Pharmaceutical Association, and of the Cleveland School of Pharmacy. For 23 years he was visiting physician at the Little Sisters' Home for the Aged Poor, and it was while returning from this institution that he was seized with the fatal attack that brought to a sudden close a useful and honorable career.

Dr. Spenser left a widow and six adult children, to all of whom he gave an excellent literary and scientific education; they are, Dr. John G., Professor of Chemistry and Pharmacology in the Cleveland College of Physicians and Surgeons, Mary H. and Eugene A., pharmacists, Mrs. J. I. Peckham, Misses Ida and Maude Spenser.

## DR. WILLIAM CALDWELL

DR. CALDWELL was born May 27, 1837, at Fremont, Ohio, a son of William and Jane A. (Davis) Caldwell, who were among the early pioneers of Sandusky and Ottawa counties.

Dr. Caldwell spent his early life in securing a liberal education and in teaching school. He next attended Oberlin College several years, and acquired his medical knowledge in the medical department of the University of Michigan, in Charity Hospital Medical College, and in Bellevue Hospital Medical College, New York, being admitted to practice in 1862. He was assistant surgeon of the Seventy-second Regiment, O. V. I., and served from April, 1863, until January 4, 1865. After the war he located in Michigan for the practice of his profession; in June, 1880, taking up his residence in Fremont, Ohio. He served as a member of the Board of United States examiners for pensions, was president of the Northwestern Ohio Medical Society, vice-president of the Ohio State Medical Society, and a member of the American Medical Association, as well as the National Association of Railroad Surgeons. He was also for a number of years a liberal contributor to several medical periodicals. His enterprise was not confined to his profession alone, for he took a deep interest in the municipal affairs of his native city. He was a member of the Masonic fraternity, Eugene Rawson Post, G. A. R., and also a member of the Loyal Legion.

On January 15, 1868, Dr. Caldwell married, at Byron, Mich., Miss Arilla, daughter of Horace L. and Elizabeth Cook. Their children were Bessie C., died 1870; Maude, now the wife of Stuart H. Perry, a young attorney of Pontiac, Mich., and Robert L.

Dr. Caldwell died September 29, 1896. It would exceed the limits of this notice to mention all the papers, addresses and lectures published by Dr. Caldwell, some of them being of permanent value, notably a recent one on Secondary Empyema.

His retiring address as President of the Northwestern Ohio Medical Association, published in the *Cleveland Medical Gazette* in February, 1889, was a valuable enquiry into the condition of the health of the ex-soldiers of the war of the Rebellion, and to what extent the vicissitudes of the war contributed to stamp upon them a more or less permanent disability. This paper was quoted largely by the medical press of the country. Dr. Caldwell was a member of the Board of Censors of the Cleveland College of Physicians and Surgeons, and was a friend indeed during all the years since he graduated from the Old Charity Hospital Medical College. Dr. Caldwell was a man of fine physique, commanding presence, genial temper, always a gentleman, had positive opinions of his own, but not offensive, always present at local, State and National Medical Society meetings, and there are few indeed whose presence will be more missed.

### Report of Cases and Exhibition of Specimens

DR. W. H. HUMISTON

#### *Double Salpingo-oophorectomy*

The patient was a married woman of 23 years of age, with a good family history. She was married at the age of 15. She first menstruated at 11 years of age, and caught cold the second day, causing cessation of the flow for three months. The function tolerably free from pain, but not perfectly regular. Within four years after marriage she was pregnant six times. She bore two children, the older one well and strong, and the younger one not robust. When 17 years of age she had a severe fever, which lasted two or three months, and caused one of her miscarriages. Recovery from the fever was slow, but by the time she was 19 she was entirely well. With the

last child the labor was hard and long, and she had to go to work within six days afterward. Menstruation since has been painful, irregular and profuse, lasting for a week, and sometimes longer. Profuse leucorrhea has followed the flow, and lasted about a week. During the past summer she has lost weight and appetite, and has had two attacks of fever lasting a week or so. She was subject to colds and heart-burn, and has had bleeding piles for the last two or three years. Her bowels are usually regular. She denies any venereal disease. On examination the uterus was found rather low down and retroflexed, enlarged, partly movable. There were tender masses in both vaginal vaults. On November 2 the uterus was curetted, the abdomen was opened and double salpingo-oophorectomy was performed. The ovaries were degenerated. The interesting point in this specimen is that both sets show the club ends of the fimbriae but they are not pervious. The last tube has no opening whatever. Of course her pregnancy must have come from an ovum coming from this right tube.

The other interesting feature of the case shows what may result from errors in diet. Her temperature was normal until the close of the second day, when it suddenly went up to 102°. She had a couple of slices of toast and a chop. Nothing else could be found to cause the temperature. Her bowels were freely unloaded and her temperature came down to 100°, and remained so that day. The next day she again had some solid food, and her temperature went up to 104°. Her pulse was good throughout. There was no inflammation of the incision or field of operation.

DR. M. ROSENWASSER: I have not yet seen the specimen, but from the history as read, would conclude that it is not as rare as supposed. The patient had evidently had a severe pelvic inflammation, which would, under ordinary circumstances, close the abdominal end of the tubes, and form the club shape. The interesting feature about one of the tubes is the opening in its side which may be an accessory *ostium abdominale*. If the condition of the tubes is congenital and not due to inflammation, one would expect a congenital deformity of the uterus as well. The precocious development of the patient, her fairly good health and her fecundity would indicate the existence of healthy tubes originally, which became crippled by disease at a more recent date.

DR. J. M. INGERSOLL

*Cystoma of the Epiglottis*

A few days ago Mrs. J. was referred to me, and gave the following history: Age 26. Her father and five brothers and sisters are living and healthy; her mother died of tuberculosis; otherwise the family history is negative. She has always been healthy herself, except that she was subject to occasional attacks of tonsillitis, which gradually decreased in frequency and severity until she reached the age of 20, when the attacks ceased entirely. For the past year she had noticed that she became hoarse after speaking a few minutes, and that at all times it required some effort to speak. There was a continual feeling of discomfort and fullness, and the sensation of a foreign body in the throat, and some expectoration of clear mucus, without any cough. The hoarseness and discomfort had increased markedly in the last four months. Examination showed the nose and naso-pharynx to be normal; both tonsils were slightly enlarged and the crypts prominent. On the anterior surface of the epiglottis, about six millimeters to the right of

the median line, a tumor irregularly oval in shape could be seen; it was about six millimeters from base to tip, and about five millimeters in diameter at its base, and projected forward at right angles to the epiglottis, toward the base of the tongue, where there was a slight depression directly opposite to the tumor. In color it did not differ from the rest of the epiglottis, which appeared normal otherwise. When felt with the probe it was somewhat compressible, rather freely movable, and not very sensitive. Except for some mucous secretions between the base of the tongue and the epiglottis the surrounding parts were normal. The right arytenoid cartilage was slightly more prominent than the left, and in phonation passed a little beyond the median line; the rest of the larynx was normal. The examination of the chest was negative; pulse and temperature normal. From the position of the tumor, situated upon the epiglottis, its color and the absence of inflammation in the surrounding tissue, and its compressibility, I made the diagnosis of cystoma of the epiglottis, and advised operation for its removal. The next day I removed the most prominent part of the tumor with Stoerk's ring pincet. The tumor immediately collapsed, and a small amount of mucoid fluid escaped, thus confirming the diagnosis of cystoma. The wound healed completely in four days, and the feeling of discomfort and the hoarseness were very much relieved. One week after the operation there was still a slight prominence where the tumor had been situated, and I cauterized this with silver nitrate fused on a probe. After two weeks the patient was able to read aloud or speak without fatigue, and the feeling of discomfort and the hoarseness had entirely disappeared. Cystomata of the larynx are rather rare, but with the exception of papillomata they are probably the most benign laryngeal tumors. They result from the occlusion of a duct or cystic degeneration of a gland, and are most frequently seen on the epiglottis. They do not tend to recur after removal.

**DR. WILLIAM LINCOLN:** Dr. Ingersoll's report deals with a new growth in the larynx of considerable rarity, but one ordinarily not easily mistaken for any other condition. The diagnosis in this case must have been more difficult than is usual with these tumors because of the natural appearance of the overlying mucosa. Generally a cystoma has a pearly translucent appearance. Cystomata, although more frequently found in or above the larynx, sometimes occur in other parts of the upper air-passages, in the nasal chambers for instance, and here they may closely simulate the ordinary mucous polyp, which has become the receptacle of a serous exudate. Histologically these serous sacs, which may occupy the entire polyp, differ from true cystomata in the absence of epithelial cells in the cyst wall. In cystoma the most radical treatment gives the best results, although disappearance of these growths may sometimes be brought about by emptying their contents and thoroughly rubbing the cyst wall with tincture of iodine.

### Program

**DR. R. J. WENNER**

*Lumbar Puncture of the Sub-Arachnoid Space, with Report of Cases*

This paper appears in full on page 549 of this number of the JOURNAL.

**THE PRESIDENT:** Lumbar puncture as a means of diagnosis is comparatively rare. This is the first time, I believe, that cases of this kind have been reported to the Society. I hope a general discussion will follow.

**DR. E. G. CARPENTER:** The paper Dr. Wenner has read is of interest to all present. The brain, the pericardium, the pleural sac, the abdomen and various other cavities have been aspirated. Now comes the question of aspirating the subdural cavities. The anatomy of the parts renders danger outside of the question. You know the cord extends to the lower border of the second lumbar vertebra. In the embryo it is still longer, reaching to the third or fourth. The dura mater with the arachnoid membrane does not terminate here. It extends downward, leaving a large cavity as far as the second sacral vertebra. In the whole cavity may be contained from 60 to 120 c. c. of cerebrospinal fluid, so that as much as 10 to 20 c. c. can be removed without interfering with the integrity of the cord. I think it would be dangerous to remove too large a quantity of this fluid. While the results of lumbar puncture have not been flattering, yet from the fact that two or three tubercular cases have been reported as recovering, we are justified in performing the operation in a great many instances. I think myself that it is indicated in hydrocephalus, in tumor of the brain, abscesses of the brain, hemorrhage into the cord, injury to the cord, paralysis following myelitis, purulent meningitis, or even chronic pachymeningitis. I think that hydrocephalus is often due to inflammation of the choroid plexus of the lateral ventricle. From this plexus is known to exude the cerebrospinal fluid, and when inflamed the fluid is produced in excess. In this sense I believe there is such a condition as an endomeningitis.

**DR. C. J. ALDRICH:** It seems to me that the particular benefit we are to derive from lumbar puncture will be an increased ability to make a differential diagnosis in certain diseases of the brain characterized by effusion. It will certainly afford means whereby we may be able to distinguish the microbic diseases. No one can, with our present means of diagnosis, distinguish tubercular meningitis from that produced by the pneumococcus. This being the fact, we have few data to prove whether a recovered case was one or the other. This operation may, I hope, afford us that much-desired information.

Fürbringer has made more than one hundred punctures in eighty-six cases. In thirty-seven of these cases tubercle bacilli were found twenty-seven times, and in all of these cases the postmortem confirmed the diagnosis. In none of these cases did any improvement result. As a means of withdrawing the blood in cases of hemorrhage into the membrane I believe it will prove of no real value. It is well known that in hemorrhage we have less to do with the fluid portion of the blood than with the organized or disorganized clot. In free opening, and not by a puncture, can we hope to benefit this condition. I question the author's unqualified statement that we are in no danger of wounding the strands of the cauda. If I remember correctly Fürbringer reported a case in which injury to these fibers caused a severe disturbance along the distribution of the sciatic nerve. Also the danger to other soft parts must be taken into account, along with that of infection. In a skilled and experienced hand as the author's there may be but little danger, but will not his statements as to the ease and innocence of the operation tempt the unequipped to its hasty and illconsidered performance?

**DR. H. S. UPSON:** Dr. Wenner has kindly asked me to say a few words on this paper, which I do with some hesitancy as I have not myself used this method of procedure. I think we very often lose sight of the fact

that the brain and spinal cord are one organ. I recall a case that I saw some years ago of a man, who in a railroad wreck was sitting in the caboose, and when the wreck occurred was thrown violently to the floor of the car. He received a scalp wound, and was for a time unconscious. He had a resulting aphasia. When I first saw him he was able to use some words fairly well, but a great many words he had not got back at all, and when he was at a loss for a word he would become very angry, his face would flush, and the madder he got the less he could talk. He had some tenderness over the left frontal region, and a good deal of headache. It seemed to me very doubtful what the lesion was in that case, but I thought I was justified in advising an exploratory incision. Dr. Jacobs, of Akron, operated very successfully, and the man made a good recovery. There had been no fracture of the skull at the site of operation; there were no spicules of bone; the dura mater was perfectly healthy. Apparently the man had suffered from hemorrhage with pressure, or from acute softening from concussion. It was somewhat remarkable that after the operation the man's speech improved for four or five weeks, and he was in every way better. A year after the operation his improvement had been maintained. That improvement might be attributed to three things: in the first place the loss of blood was very considerable; in the second place, the blood-vessels that were cut were occluded and the circulation decreased, and lastly the pressure was relieved. I believe this last was the main reason why he improved after the operation. I have seen quite a good many cases of brain tumor in which the opening of the skull was followed by good results, even without removal of the tumor. It seems to me if lumbar puncture can take off the pressure, and so determine alleviation of the symptoms, we are justified in doing it. Apparently the stronghold of the surgeon in this operation is tubercular meningitis. Whether there is real benefit in such cases we have not yet experience enough to be sure, but no one will question the value of this procedure as a diagnostic measure. That it is dangerous I have no doubt, but every surgical procedure is dangerous, and we must remember that the conditions in which this operation is used have been hitherto almost hopeless. We are very much indebted to Dr. Wenner for experimenting in this line, and giving us the benefit of his experience.

**DR. A. F. HOUSE:** From the surgical point of view I am satisfied from the number of cases I have witnessed, that it is not only a palliative or diagnostic measure, but in some cases also curative. Ziemssen has employed it a great number of times in cerebrospinal meningitis, hydrocephalus, tubercular meningitis, brain tumor, and several different spinal affections, with some very marked results. Spinal drainage may be performed in various ways, not only by puncture, but by establishing permanent drainage. Quinke has used permanent drainage in quite a number of cases of tubercular meningitis, and also hydrocephalus, with the result of curing two cases by making pressure upon the cranium, at the same time establishing permanent drainage. Hope removes the spine and right lamina from the second lumbar vertebra, punctures the theca with a knife, and introduces a drainage tube for permanent drainage in cases of tubercular meningitis, and also hydrocephalus. Gould has, I think, done the same operation, with the exception of uniting the theca with the surface of the wound in order to dispense with the drainage tube. I was present at all the punctures that Dr. Wenner has made with the exception of one; and the amelioration in the

head symptoms was quite marked. This palliative measure certainly has some remedial influence on the headaches.

DR. WENNER: In reply to Dr. Carpenter, I would say that 115 c. c. of fluid have been removed without any dangerous symptoms. The good results in hydrocephalus are not permanent. The convulsions are relieved. Wolfstein punctured a case that had been diagnosed by three or four as tubercular meningitis. Lumbar puncture showed it was a case of pneumococcus infection. The benefit in tubercular patients is not only diagnostic but also curative. I mentioned two cases of hemorrhage of the cord, of whom one patient recovered entirely, and the other almost entirely. There have been reported between three and four hundred cases of puncture, and only two of untoward symptoms. Of the cases Dr. Aldrich mentions, one entirely recovered, the other with slight paresis of the muscles of the thigh. There have been no deaths which could honestly be ascribed to puncture. The case of cerebellar tumor would have died any way; the death occurring 48 hours after the puncture does not warrant us in saying the death was from puncture.

On motion the regular meeting of the Society will be held on the first and Third Fridays of December. The remainder of the evening was occupied by an exhibition of X-ray apparatus, including the fluoreSCOPE.

DR. WALTER WYMAN of the Marine Hospital Service, will lecture before the Society December 18.

### Union Medical Association of Northeastern Ohio

The One Hundred and First Quarterly Session of the Union Medical Association of Northeastern Ohio was held at Canton on Tuesday, November 10th, with the President, Dr. H. S. Upson, in the chair.

DR. M. M. BAUER of Lake, reported a case of "Puerperal Thrombosis."

DR. H. S. STRAIGHT of Cleveland, said he had had under his care some years since, a large, heavy woman, 45 years of age, who was thought to have some uterine disease. Her left leg was enormously swollen from thrombosis of the vein. The leg was extremely tender. The consulting surgeon of the Hospital, Dr. Vance, made a slight puncture, and let out a few drops of blood, stating that in some such cases this was followed by a marked improvement. A wonderful reduction in the size of the leg did in fact follow the operation. Some weeks later the patient became suddenly hemiplegic and died in a few hours. He saw another patient with pneumonia of the right lower lobe of the lung, and was sent for suddenly one night and found the patient in collapse, with extreme dyspnea and rapid pulse. He gave stimulants. The next day it was evident that thrombosis of the vein in the calf of the right leg had developed. In a Sister of Charity, aged 22, whom he saw with follicular tonsillitis, a week after her illness he found her with slightly injected conjunctiva and coated tongue. She seemed a little bilious, and he prescribed salts. Two weeks later, on getting up in the night, she fell and vomited. She developed a fairly marked loss of motion in the right side. She has made a fairly good recovery. These cases of thrombosis are very interesting and are rather hard to explain.

DR. H. S. UPSON of Cleveland, said he had seen lately a patient who has had successive attacks of hemiplegia. He was a man under 30 years



old, of medium stature, thin, and rather anemic. He has had in all some half dozen attacks, which came on usually in the night or early in the morning, at the time of the lowest vitality of the organism. The paralysis was fairly rapidly recovered from, but always left traces. There was absolutely no specific history, and no discoverable reason for the attacks. The probability in these cases is much in favor of thrombosis, from the absence of heart disease or other symptoms of emboli, from the asthenic condition of the patient and absence of arteriosclerosis, and from the fact that the attacks occur at a time of day when the heart-beat is feeblest and bodily functions are less active. Cerebral hemorrhage, as is well known, is much more apt to occur later in the day, and especially after a full meal.

DR. J. F. HOBSON of Cleveland, reported a case of "Compound Fracture of the Leg." This paper appears in full in this number of the JOURNAL.

DR. T. W. JACKSON of Akron, was reminded of a case he saw some ten months ago. The patient was a country boy, who was thrown from a horse, and sustained a comminuted fracture of the left tibia and simple fracture of the left fibula. The wound was full of dirt and horse manure. The boy was removed to the hospital. After scrubbing with ether and an anesthetic solution he cut down and aligned the tibia as nearly as possible, removed bits of bone, dirt and cinders, and subjected the wound to constant irrigation for three days with a fountain syringe. The parts, at the end of that time, were in good condition. He then put on a starch dressing, with an opening for drainage. In four weeks the patient was feeling quite well, and in eight weeks he left the hospital, and has now only a scar to show that he sustained an injury.

DR. STRAIGHT believes that the surgeons are fully awake to the danger of sepsis, but that physicians are not aware of the importance of septic processes from autoinfection. A relative of the speaker who was seen in July last had been, at that time, sick for a number of months. He was about the house, but upon examination was found to have a temperature of 103°. The liver was large and tender, but no enlargement of the spleen could be made out. The *plasmodium malariae* was found in great numbers in the blood. Quinin improved his condition, but did not cure him. He seemed to be in a septic condition, his pulse became more and more rapid, he developed *petechiae*, went into a stupor, and died a week after he was first seen.

DR. J. FRAUNFELTER said that we are liable to meet with these cases at any time. They should be treated as open wounds. He finds wet dressings are better than dry. When the vessels are destroyed, the limb very often cannot be saved, whether the fracture is compound or not.

DR. HOBSON in closing said that Dr. Jackson's case was certainly very favorable for the development of septic trouble if he had not used an antiseptic solution. The speaker sometimes used solutions of bichlorid of considerable strength, as much as 1 to 3,000 or 1 to 4,000. In one case of extensive crushing without fracture, in which the leg was practically pulpified, he warned the parents that the boy would die unless an operation was performed. The parents, however, withheld their consent. In 36 hours the toes blackened, and a few hours afterwards the whole leg was black. The parents were then anxious for the operation, which was performed, and the boy fortunately made a good recovery.

DR. C. B. PARKER of Cleveland, read a paper on "Syphilis in Childhood." He said that these cases occur much more frequently than has been thought, not only in the hereditary form, but as acquired from nurses and other persons. A young gentleman from Roumania said to him: "Why, every young man in Roumania drinks iodid of potash." In the London hospitals \$4,000 have been spent for iodid in one year.

DR. A. R. BAKER: In many cases interstitial keratitis is overlooked. Choroiditis is more obscure, but very commonly present. The hereditary form of syphilis often shows itself first in the eye by one of these two conditions.

DR. E. CONN said that many of the diseases which are so fatal in childhood in the hot season are really hereditary syphilis. He cited several cases.

DR. STEELE had a patient whose first five or six children all died in their infancy. Three years ago a boy was born who had eruptions and cracking off of the nails. The father admitted that he had had a specific trouble. Black wash and mercury cured the boy, and he is now as healthy a child as there is in that town.

DR. PARKER said there were only two methods of treatment which, in his opinion, are valuable in these cases, inunction, or the Vienna method, and the Hutchinson method. He thinks the protiodid the worst possible agent. Many may disagree with this statement, but have you followed your cases four or five years? Inunction; as practiced at the Hot Springs of Arkansas and Mount Clemens, is followed by good results. The person should rub himself, unless his rubber uses gloves. We are all afraid of salivation. To prevent this, send the patient first to the dentist's, and have all the cavities in his teeth filled. He should, during treatment, clean his teeth and mouth six times a day, then rub in at least a drachm a day of the ointment. The Hutchinson method consists in the giving of mercury with chalk, and it is excellent, especially in children. To an infant, give one-half to a quarter of a grain, and to an adult, one grain of gray powder, three times a day. Syphilis in all stages cannot be treated by iodid alone; mercury must be given in good large doses in connection with it. That has been the speaker's experience, and is his opinion. Syrup of the iodid of iron is excellent, and cod-liver oil very useful in many cases. The method used in the hospital in Great Ormond Street, London, is to tie up the infant in a bag with cod-liver oil; an easier method is to tie cod-liver oil compresses over the abdomen.

DR. HOBSON reported a patient who had syphilis six years ago. He had been under Dr. R. W. Taylor, of New York. He was seen a few days ago suffering from intense pains. He had been rubbing in a drachm of mercuric ointment night and morning, and had taken a prescription containing ten grains of potassium iodid and one-sixth of a grain of mercuric biniodid three times a day. His case was diagnosed as syphilitic neuritis and phlebitis. His arm would be numb, and tingle up to the shoulder. Blood clots were passed in the stools. The pain subsided on stopping the mercury. The speaker would like to ask the chairman his opinion of such pains in their relation to the nerve-trunks.

DR. UPSON said, in answer to Dr. Hobson's question, that he had been much interested in this matter of pains following syphilitic infection

We have to differentiate the pains of locomotor ataxia from those due to mercury as described by the speaker. He saw recently a physician who had had a syphilitic infection some six years ago. The patient had very severe shooting pains, which he was disposed to ascribe to locomotor ataxia, a disease with which he was familiar. The knee-jerks, however, were present, there were no eye symptoms, he had no ataxia on walking. These angiospastic pains are exceedingly sharp and cutting pains, neuralgic in character, and superficial, whereas the pains from mercury are aching and deep-seated.

The next meeting will be held in Akron in February. The following program was announced by the President: Essays, Drs. Wirt and E. P. Morrow; Lecture, Dr. Bowman; Reports of Cases, Drs. Marchand, Hamann, Rabe, and Baker, of Louisville; Discussion, Drs. Rosenwasser and Brannan.

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### The Cleveland Medical Society

IT is to be regretted that this live, energetic, active medical society, with over three hundred members, should have any trouble with either the Ohio State Medical Society or the American Medical Association. The prime object of every medical society should be the advancement of the medical profession, collectively and individually. It has long since been demonstrated that medical societies organized for disciplinary purposes alone do not thrive as the proverbial "green bay tree." We do not mean by this that medical societies should be without discipline, or should be run without a code, constitution or by-laws, but we do mean that the constant agitation of insignificant matters, in order to pay off old personal scores, has done much to interfere with the progress of local, state and national associations.

At the last meeting of the Ohio State Medical Society it was demonstrated, beyond a question, to the members of that society that whatever was lacking on the part of the Cleveland Medical Society to make it eligible to membership in the State Society had been remedied, and therefore it was considered eligible to membership, and by a practically unanimous vote, when there was a large attendance of the members and delegates, representing nearly every county in the State, this society was voted in, and is now as much one of the auxiliaries of the State Society as any other. The fact that it has removed the obstacles which prevented its admission to the State Society should make it eligible to the American Medical Association, and at the next meeting that organization should exercise its authority in admitting it to membership. In the meantime we believe in discouraging any secession of either the Ohio State Medical or the Cleveland Medical Society until the American Medical Association has been given a fair opportunity to act on the merits of the case. We hope and believe when such opportunity is given they will receive fair and just treatment. If they do not, then it

will be time enough for them to vindicate their sense of justice by taking such action as may be deemed proper under the circumstances. There is too much at stake for either society to take any rash action in the matter. An upright, dignified course is the best one for them to pursue, being content to rest their case on its merits, and the good judgment of level-headed disinterested parties.—*Columbus Medical Journal*.

## Book Reviews

**PHYSICIANS' VISITING LIST FOR 1897.** P. Plakiston, Son and Co., 1012 Walnut Street, Philadelphia, Pa.

This visiting list now, in its forty-seventh year, is too well known to physicians to need any introduction. Notwithstanding that its age and popularity are sufficient to guarantee a state nearly approaching perfection, some improvements are announced for this edition. The right hand red line on the left hand page has been moved one-eighth inch to the left; four blank pages have been added to the General Memoranda, and twelve pages to the Cash Account. The cover has also been materially strengthened. Probably no other visiting list is so popular among physicians, and no one questions that the popularity is deserved.

**HEALTH IN THE HOME**, a practical work on the Promotion and Preservation of Health, with illustrated prescriptions of Swedish gymnastic exercise for home and club practice, by E. Marguerite Lindley, Lecturer on Health Culture, New York. Published by the author. Murray Hill Hotel, 1896.

This work is intended for women whose need of instruction in methods of exercise and in hygiene is very great. The book is written in plain, easily understood style, and cannot be perused without profit. The advice given is very common-sense, and the scope of the work is quite extensive. Special chapters are devoted to a consideration of the most important bodily functions, and to the care of children. Naturally most of the work, twelve chapters, is given up to a consideration of plans of exercise. Chapters are also devoted to massage, bicycling, fatigue, regulation of flesh, dress, bathing, nursing, etc. While the ground covered is large, the work is, of course, not exhaustive, being intended for elementary popular instruction, which purpose it will fill excellently. It is a good work for physicians to recommend to ladies whose need is for exercise and better hygiene, rather than for medical care. For this purpose it is excellently well-adapted.

**DONT'S FOR CONSUMPTIVES, OR THE SCIENTIFIC MANAGEMENT OF PULMONARY TUBERCULOSIS**—How the Pulmonary Invalid may make and Maintain a Modern Sanitarium of his Home, with Additional Chapters Descriptive of How Every Consumptive Person May apply the Forces of Nature to Assist and Hasten Recovery. And, also, How the Defects of Heredity may be Best Overcome. By Charles Wilson Ingraham, M. D., Binghampton, N. Y. February, 1896. *The Call*, Binghampton.

The hackneyed title of this book detracts nothing from its unquestionable merits. The reading public, however, has been sated with "Don'ts"

of so many varieties and for so long that a new work with that title tends to be repellant and is in danger of being judged *passee* without further investigation. This is unfortunate as the work is eminently practical and capable of great usefulness to the physician, and also to his patients.

Despite its humble title the work is exhaustive in the range of subjects covered and is thoroughly done as well. There are chapters on Expectoration, Contagion, Infection of Houses, Infected Milk and Meats and on clothing, food and exercise for the consumptive.

The question of treatment, especially climatic, is well covered and the importance of having a careful diagnosis made in each suspicious case is insisted upon. It is impossible to give an extended review of the book and indeed none is necessary further than the statement that it is thoroughly modern in all its teachings and each point is well covered. Physicians will find pleasure and profit in reading this book themselves and will find it a perfectly safe one to put in the hands of their intelligent patients. It is to the patient that the book is directed and there is where it is calculated to do much good. This work put in the hands of his tubercular patients, would be of great service to the physician in making them more attentive to his advice upon all matters relating to the prevention and management of the disease. Physicians should either send for a sample copy of this work or make a note concerning it for use when occasion arises.

**MORTALITY FROM SUICIDES**—A report by Elias J. Marsh, M. D., Medical Director, to the Mutual Life Insurance Company of New York. 1896.

This very interesting report covers with accurate statistics a matter which is of great interest to the medical profession. The report opens with the general statement that for the first 30 years of the Company's experience, from 1844 to 1873, 1.1 percent of deaths of persons insured in the Company were due to suicide. During the succeeding ten years 2.1 percent were due to this cause. In a former report it was shown that the mortality from accidents had increased at a ratio about proportionate to the general death rate; but the present report shows that deaths from suicide have increased at a threefold ratio. The table shows that suicide takes place at all periods of mature life and that in the United States the revolver is the favorite method. Curiously enough, the figures show that drowning is very seldom resorted to by persons under 50 years of age and that poisons are seldom used by persons above that age. Those of German descent and birth seem most prone to take their lives. As is well known, the proportion of suicides is greater in the densely crowded cities. A very few cases occurred among farmers, while a vast number were among men engaged in one kind of business or another. No evidence of any family tendency to suicide can be made out from the experience of this Company. The most important conclusion of the report is that "in proportion to the lives at risk the number of suicides has been less now than formerly during the first two years' exposure, but that for the third, fourth and fifth years of exposure the number has more than doubled its earlier proportion." Very naturally the inference is suggested that the reason for this fact is to be found in the rule made by the Company at the beginning of the last period that in case of death from suicide during the first two years of insurance the family is not to receive any benefit therefrom.

## Medical News

**Diphtheria** has been widely epidemic lately throughout the State of Illinois.

**The Cincinnati Medical Journal** has joined the ranks of the dear departed.

**Dr. Dudley P. Allen** returned November 27 from his extended European trip.

**Dr. J. F. Baldwin** of Columbus is at present in Paris, attending the gynecologic clinics.

**Baltimore** has just elected two physicians, Dr. Isaac A. Barber and Dr. William S. Booze, to Congress.

**The Central Medical College** has just been incorporated in Chicago. None of the promoters are physicians.

**Weir's Index** to the Medical Press will not suspend publication we are pleased to announce, but will be continued as heretofore.

**A Physician** (?) of Columbus who plies the calling of an abortionist has just killed a victim and the law is setting its clutches on him for murder.

**Two physicians** of Cleveland are accused of having forged diplomas in order to register under the new law. Both are of the homeopathic faith.

**Dr. B. O. Coates** left for Europe December 1, to be gone one to two years. He will spend a large part of his time in London and Edinburgh.

**The Philadelphia lazaretto** has been turned over to the health authorities for use as a hospital for consumptives, in order that they may be isolated.

**Dr. J. H. Bushnell** a former Ohio physician and relative of the present governor of the State died in Washington, D. C., October 31, at the age of 82.

**The annual report** of the Youngstown City Hospital recently submitted to the trustees, by the staff, shows the institution to be in a flourishing condition.

**Dr. H. R. Carter** of the Marine Hospital Service has been assigned to the Chicago station recently made vacant by the resignation of Dr. John B. Hamilton.

**With its customary enterprise** the *Medical Record* issued a "Winter Resort" number on October 31, which is a credit to its publishers and a useful aid to the physician.

**Starling Medical College** at Columbus has made a horizontal increase in its fees along with the inception of the four years' course, much to the displeasure of the students.

**The Rochester** Pathological Society has petitioned the City Council for an ordinance permitting physicians to ride their bicycles on the sidewalks between the hours of 10 p. m. and 6 a. m.

**An editorial** in the *Pittsburg Dispatch* of November 2 warmly commends the efforts of the medical profession of that city looking to the securing of a building for the use of the medical societies.

**The San Francisco** papers announce with great flourish that the physicians of that city have formed an intricate secret organization to fight the dispensary, lodge-practice, and other abuses.

**Dr. O. W. Schmidt**, the genial representative of Fairchild Brothers & Foster spent the month of November in Cleveland, canvassing the profession in the interests of the products of this well-known firm.

**Dr. Joseph E. Cook**, President of the Cleveland Medical Society, was married November 19, to Miss Lillian Elizabeth Heisley. The best wishes of the whole profession of this city are extended to them.

**The Dean** of the Indiana Medical College at Indianapolis is bitterly accused by ten Muncie physicians of using the school for political purposes in endeavoring to influence the students to vote against Bryan.

**Dr. Cyrus Edson** of Aseptolin and Ammonol fame is greatly in demand. He has gone to Europe to treat with aseptolin a Royal Prince suffering from tuberculosis. At least so his assistant announced to the papers.

**The Pall Mall Magazine** for December contains the first installment of a psychologic story by William Waldorf Astor. Hysteria and a firm belief in the transmigration of souls are prominent features in the tale.

**The Columbus Press** of October 28, announced that 500 physicians had banded together to fight the medical law. The story is evidently a "fake". Certainly the State Board is losing no sleep over the matter.

**The Cincinnati** Hospital is said to be in a most dilapidated condition requiring at least \$5,000 to render it habitable. The food furnished patients is also said to be of totally unfit quality and, in general, the institution needs reformation.

**A member** of the faculty of Barnes Medical College, St. Louis, writes us that their college does not propose to fight the rule compelling students of medicine to undergo a preliminary examination as to their educational qualifications.

**Brooklyn, N. Y.**, is a highly honored city. A homeopathic doctor there announces in a half-page of the daily papers, with portrait of himself, his library and his laboratory, that he has found the "bacillus of death" and that there is no further need to die.

**A number** of American medical editors have taken to writing poetry and

publishing the results in their medical journals. The matter is somewhat serious and it is to be hoped that the epidemic will be got under control before irreparable damage is done.

**On an unpretentious** house on Rockwell Street, this city, appears the following interesting announcement: "Spirritul clairvoyant controled by a child born with a vail price 35c."

**At the November 27** meeting of the Cleveland Medical Society the following non-resident members were present: Dr. W. C. Bunce, of Oberlin, Dr. Gustav Shane, of Waynesburg, and Dr. C. A. Snow, of Garrettsville.

**The Northwestern** Ohio Medical Association will hold its semi-annual meeting at Defiance, December 10 and 11. An excellent program has been announced, and the meeting promises to be a very profitable one.

**Dr. O. D. Norton** of Cincinnati, has recently celebrated his jubilee of practice, having resided in Cincinnati the whole 50 years. He is an active member of the Academy of Medicine, and was one of the founders of Cincinnati's Natural Science Society.

**Dr. Walter Wyman**, Supervising Surgeon-General of the Marine Hospital Service, will address the Cleveland Medical Society on Friday evening, December 18. A large attendance is anticipated, as the address is sure to be of great interest to the profession.

**Dr. Elisha Griswold** of Sharon, Pa., died October 3, at the age of over 60 years. He graduated from Jefferson Medical College in 1858, and was one of the leading physicians of western Pennsylvania. He was surgeon to the Erie Railroad, and had many friends in Cleveland.

**The Illinois** State Board of Health on November 10 turned down the National Medical School, the Illinois Medical College and the Dunham Medical College, all of Chicago, for non-compliance with the requirements of the Board, and refused their diplomas.—*Lancet Clinic*.

**Dr. Frank C. Corey**, of Warren, a graduate of the Medical Department of Western Reserve University in the class of 1875, died November 25, after a brief illness. He practiced in Rock Creek many years, having moved to Warren only about five years ago. A widow survives him.

**Dr. Clark Townsend** died at his home, 39 Holyoke Place, October 29, of apoplexy, at the age of 41 years. He was valedictorian of the class of 1879, at the Wooster Medical College. He was a student and *protege* of the late Dr. W. J. Scott. A widow and one child survive him.

**Dr. Edwin S. Ricketts** of Cincinnati sued Mrs. Caroline Violet of Portsmouth, executrix of the late John M. Violet of Harrisonville, for \$800 unpaid balance on a bill of \$1000 for an operation for abscess of the liver. The jury awarded \$217.50 and the plaintiff promptly appealed.

**A typhoid** epidemic in one quarter of Chicago has been traced to milk



coming from a dairy in an Indiana town where there were 50 cases of typhoid and no sewage. Contaminated well-water was of course added to the milk. The local physician did not surmise the danger, however, but left that to the Chicago authorities.

**A Columbus** physician is being sued by the father of a pair of twins because after the preliminary visit he sent a substitute physician who delivered one child safely, but is alleged to have been "rattled" at the appearance of the second one and to have caused its death by unskilfulness. The price asked for the missing twin is \$5,000.

**The Medical Association** of Central New York at its recent meeting elected the following officers: President, Dr. E. B. Angell, Rochester; first vice-President; Dr. William C. Krauss, Buffalo; second vice-President, Dr. F. H. Stephenson, Syracuse; Secretary, Dr. Van Der Beek, and Treasurer, Dr. S. L. Elsner of Syracuse.

**The following** gentlemen from out of town were, among others, present at the November 13 meeting of the Cleveland Medical Society, Dr. Gustav Shane of Waynesburg; Dr. O. T. Maynard of Elyria; Dr. Frank Winders, Secretary of the State Board and ex-Attorney General J. K. Richards, Counsel to the State Board, of Columbus.

**The retiring** president, Dr. E. B. Smith, of the Wayne County Medical Society (Detroit), among other things recommended in his address that the Society should name a republican and a democratic physician to their respective parties as suitable men for the office of Coroner. This is an excellent suggestion, and might be employed with benefit in Cleveland.

**In a suit** for \$3,425 against Mr. E. C. Camp for extended medical services by Dr. C. E. Ristine at Knoxville, Tenn., the judge (of the Supreme Court) ruled out all evidence submitted to show the abundant wealth of the defendant and stated that a rich man should be charged no more than a poor one. The court should see that this rule is applied to the legal profession first.

**Dr. J. B. Murdock**, Clinical Professor of Surgery in the West Penn Medical College, and one of the best known surgeons of Pittsburg, died of renal disease October 29, at the age of 66. His was a long, active and honorable career, including service all through the war. He was a native of Glasgow, Scotland. His contributions to surgical literature were many and of a high order.

**The Commercial** Mutual Accident Company and the Provident Mutual Accident Company have each been sued for \$5000 by the widow of Dr. William K. Mattern, late coroner's physician, of Philadelphia, who is alleged to have died solely from the effects of septic poison from a dissection wound. This sort of injury was covered by the policies. The companies' reason for refusing payment will be stated later.

**Sir Benjamin Ward Richardson**, M. D., F. R. S., the world's leading authority on hygiene and sanitary science, died in London, November 21, at the age of 68 years. Dr. Richardson who was knighted in 1893 was probably the most widely renowned physician in the world, largely by reason of his multitudinous writings. In his later years he was an ardent bicyclist, and at death was president of the Society of Cyclists.

**An interesting** case is on trial in Pittsburg. By the testimony of a Dr. George T. McCord, a man secured \$6,000 damages for injury from the Central Traction Company. The lawyers took \$3,000 for fees, one getting \$1,900 and the other two \$550 each. The doctor is now suing the lawyers for a small fee, having been paid nothing, and each lawyer is trying to prove that the other one should pay the doctor's fee.

**The Ohio** Medical College, now a department of the University of Cincinnati, finds itself in a predicament over the color-line. Because of its large number of Southern students colored men have never been permitted to matriculate. Now that it is a portion of the University it is probable that the State law will compel it to make no distinction upon the basis of color of skin. A case in point has arisen, and the result will be interesting.

**Although** Chicago has her water in-take several miles out in the lake, she finds that under favorable circumstances her citizens must frequently drink sewage and die of typhoid fever. The authorities are now convinced that the only remedy is to keep sewage out of the lake.

The tunnel extension scheme of Cleveland, now under way, will also be an utter failure in protecting our citizens from disease if sewage is not kept out of the lake.

**Dr. S. P. Anderson** of Allegheny, Pa., drew \$200 fine and 5 years in the penitentiary for performing an abortion upon a young woman, who died as a result of the proceeding. This was not the criminal's first case. No defense was made, but the court was appealed to for mercy because of an aged mother. It may be noted that the omission of defense was because of its evident futility in the face of overwhelming evidence. Judge Slagle found no reason for mercy.

**Zero**, the Indian doctor, came to grief in Minster, Auglaize County, recently, through the activity of Dr. C. L. Dine of that town, and of Dr. Frank Winders, Secretary of the State Board. A patient of the Indian doctor's died suddenly after four days' treatment, but necropsy failed to show any connection between the two facts. He was detained however for having no certificate from the State Board. Upon promising to leave the state Dr. Dine let him off.

**The cornerstone** of the new St. Margaret's Hospital in Pittsburg was laid October 16, with imposing ceremonies conducted by high dignitaries of the Episcopal church, among them Lord Bishop Dowden of Edinburgh,

Scotland. The hospital is being rapidly built under the terms of the will of the late John H. Shoenberger, who left \$800,000 and a large tract of land for the purpose. The buildings are designed by Ernest Flagg, architect of St. Luke's Hospital, New York.

**Prosperity of the Dispensaries.** Private practice in and about New York is reported to have been unusually quiet during the early fall. Not so in dispensary service. During the month of September 124,081 patients were treated at the outdoor department of Bellevue, against 92,434 in September, 1895, an increase of 25 percent. The factors accounting for this would seem to be hard times, increase of poverty, and a tendency on the part of the frugal minded to save on the doctor's bill.—*Medical Record*.

**The Journal** has received from Messrs. William Wood & Company a very acceptable present in the shape of a photogravure entitled "Anesthesia." It is commemorative of the semi-centennial of the discovery of ether by Morton, which has just been celebrated in Boston and elsewhere. The picture is printed from a steel plate, by the usual photogravure methods, reproducing exactly the work of the artist, and is an exceedingly decorative rendering of an idea suggested by Morton's great discovery. The publishers are tendered the thanks of the JOURNAL for this valuable compliment.

**During** the latter part of October and the first two weeks of November, this city suffered from a somewhat sharp epidemic of diphtheria which was the cause of 39 deaths in October. The worst of it was confined to the so-called "tenderloin district" necessitating the closing for a week of the Rockwell School, which was then thoroughly cleaned and fumigated. When the school reopened the children were required to present medical certificates attesting their freedom from disease. Subsequently cases occurred sporadically in widely separated districts of the city and then decreased rapidly in number.

**False Alarm :—**There is a physician in Cleveland who is pretty sure to stutter when under the stress of excitement. Some time ago he had occasion to officiate professionally on an interesting occasion, and his vocal infirmity was the cause of a funny misapprehension. The husband and the prospective father, who, by the way, had set his heart on a son and heir, was nervously pacing the library when the doctor entered. "Well, doctor," cried the husband, forcing a smile, "is it twins?" "Tr-tr-tr-," began the doctor. "Triplets! Great Cæsar!" "Qu-qu-qu—" stammered the doctor. "Quadruplets! Holy Smoke!" "No, no," cried the doctor. "Qu-qu-quite the contrary. Tr-tr-try and take it ph-philosophically. It's just a girl." *Cleveland Plain Dealer. Medical Record.*

**Dr. Frank Winders** and ex-Attorney-General J. K. Richards, Secretary

and Counsel respectively for the Ohio State Board of Medical Registration and Examination were in Cleveland, November 13 and 14. During their stay the *Journal* office was their headquarters and plans were perfected for at once enforcing the law here in the same manner as has already been done in Cincinnati and Columbus. In fact this city is about the only remaining portion of the State where all practitioners of medicine have not been compelled either to obtain a certificate or close up shop. In the short space of six months, through the efficiency of the Board and its Counsel, the new law is being strictly observed in nearly all parts of the State. Great numbers of illegal practitioners have left the State rather than risk conflict with the law. A number have thus disappeared from our own city. The Secretary believes that in all the State there are less than 100 practitioners who have not yet complied with the terms of the law.

**Mr. George S. Davis**, General Manager of the big drug house of Parke, Davis & Company of Detroit, has retired and leaves shortly for California to take a protracted and much needed rest. No change whatever in the business or policy of this great house will ensue upon Mr. Davis' retirement. Mr. William M. Warren, who has been connected with the house for many years, and has for two years been its virtual manager, has been elected vice-president and general manager of the company to succeed Mr. Davis. Mr. Davis however retains a nominal connection with the firm as advisory manager. In announcing that there will be no change in the policy of the firm, the new manager, Mr. Warren, says the business of the firm was never before so prosperous. In spite of the commercial distress this great house has in ten months of 1896, done \$200,000 more business than in the same period of 1895. It is to be regretted that the private interests of Mr. Davis have suffered somewhat, even while his firm was so prosperous. Mr. Davis' generosity to the medical profession in conducting the *Index Medicus* for a number of years at a steady loss, will not be forgotten by physicians, and it will be a general wish that his reverses shall prove only temporary.

**A very interesting** medicolegal case will be heard in the local courts early in January. It comes up in the shape of a suit for damages against the Grasselli Chemical Company whose works in Newburg cast into the atmosphere a large amount of sulphurous acid and free chlorine. The attempt is to prove that the gases are detrimental to health. It is easy to prove that these gases in the laboratory are harmful, but not so easy when they are free in air. It is a reasonable inquiry as to whether their inhibiting effect upon germ-life would not counteract the harmfulness of their irritating qualities. Some 15 years since Dr. G. C. Ashmun, then health officer, looking up carefully the death-rate of this part of the city as compared with other quarters, found no excess of mortality, and at the present time the maximum area of mortality is not in that direction. The works were located some

thirty odd years ago and the city has since grown out to them, so that those who live there deliberately chose that quarter for residence; but an English Court has held that the natural growth of the city may not be obstructed by a nuisance. Then the output of the works is much greater than formerly. In humid weather the corrosive effect of the gases is most marked, probably by reason of a combination of the sulphurous acid with watery vapor to make sulphuric acid, which settles on all objects and rapidly corrodes all metal articles and also canvas awnings and other like objects. The depositions of the expert chemists, however, are not in accord as to the amount of the harmful gases in the air.

Altogether the problem presented for adjudication is one of the most difficult possible.

**Dr. W. B. Ransom** of Nottingham, England, writes to the *Boston Medical and Surgical Journal* that his name appears signed to an objectionable testimonial in a pamphlet advertising Sanmetto, entirely without his knowledge and consent. He asks if legal remedy is obtainable.

**A Physician** of Harrisburg, Pa., having been convicted of malpractice and sentenced to two years in the penitentiary made a piteous appeal for mercy for his luxurious beard from the merciless razor of the State's barber. He evidently recognized his beard as a useful adjunct to his business.

**Secretary of War** Lamont estimates the expenses of his department for 1897 at \$52,875,638. Of this sum, barracks and quarters including hospital construction need \$835,000; medical supplies will be needed to the extent of \$40,200; and soldiers of the late war will get \$191,000 worth of artificial limbs free.

**The Dental Department** of the Cleveland University of Medicine and Surgery (homeopathic) has just been discontinued by a vote of the Board of Trustees. The reason given was that there could be no *homeopathic* dentistry and as this city already has one flourishing dental school, another is unnecessary.

**Brooklyn, N. Y.**, possesses the proud distinction of having as a citizen the Rev. George Cermor Fair, pastor of the First "Apostolic" Church. Mr. Fair preached September 20 on "Doctors, Drugs and Devils." He said physicians and drugs were the agents through which the devil works. "The doctor's profession is inspired by the devil. You people are all dopy to submit to them." Thus the Associated Press quoted him.

**Mr. Theodore Roosevelt** posed as an alienist in a recent speech at Chicago. He said among other things:

"It is not merely school girls that have hysterics; very vicious mob leaders have them at times and so do well-meaning demagogues when their heads are turned by the applause of men and their minds are inflated with the possibility of acquiring solid leadership in the country."

**The Roentgen** ray as an aid to diagnosis is not being neglected. One of our prominent physicians has secured the services of a competent electrician, skilled in this special line, to work with him in his office and properly use the apparatus upon cases referred for diagnosis by other physicians. An enterprising druggist has made a partnership with an electrician and they announce their readiness to do this work for physicians. As noted elsewhere a couple of doctors advertise to the public that they treat a large proportion of diseases by this method.

**Mr. Preserved Grant** and his daughter Mrs. Ferry of Chardon, Geauga County, were badly burned October 12 by the explosion of a patent medicine which they were preparing for market. Mrs. Ferry's eyes were blown out, her hands were torn off, and she will probably die, as will also her little daughter.

While not withholding sympathy from the afflicted, congratulations are due the public in general for its narrow escape. Probably even the public may appreciate that ignorance which permits careless handling of dangerous chemicals is hardly equipped to minister to the ills of humanity.

**The Middle Ages**, with their gigantic hysterical epidemics, dancing manias, flagellations and crusades are not very far in the past. Despite our civilization reversion to the superstitions of the savage are yet almost daily chronicled in the newspapers. In Central Park, New York, all diseases are being cured by walking barefoot on the damp grass. At Bluffton, near Decatur, Indiana, is being held a State meeting of the "Pentecostal band" whose performances closely resemble those of the Dervishes of Oriental lands. They gather about an altar and pound their heads and hands on the floor until they are often seriously bruised. They eat nothing during the meeting and many of them go into cataleptic "trances" which last for hours. The pessimist who holds that our boasted high civilization is but a veneer of culture over an enormous substructure of pristine savagery and superstition can be imagined cracking a dry smile at the reports of these backslidings in human progress.

**We regret** to learn of the death of Mr. James Christie, the affable, whole-souled representative of Fairchild Bros. & Foster, which occurred at Duluth, Minn., September 16. Mr. Christie was known to all the leading men in the profession in the Mississippi Valley, and his untimely death is greatly to be regretted. His good nature, frank, open friendship, and his many manly qualities endeared him to all with whom he came in contact. We extend our heartfelt sympathy and condolence to his bereaved parents, his brothers and sisters, and to his employers, who have lost a faithful and willing servant.

The sad news of Mr. Christie's death reached St. Paul during the session of the Mississippi Valley Medical Association, and appropriate resolutions were adopted at a special meeting of the exhibitors, expressing a unanimous sentiment of sympathy and fond remembrances.

**Two students** of the Illinois Medical College, a senior and a junior, have run foul of the law in attending two cases of diphtheria in Chicago, both children having died.

**A diphtheria** epidemic has arisen in Waltham, Mass., in a tenement house, used as a boarding-house by workmen employed in excavating the Cambridge water-basin.

**Dr. C. E. Brown-Sequard**, son of the famous physician of the same name, died October 13 in Atlanta from the effects of a sunstroke received last summer. He was 40 years of age and was born in Paris. For three years he had been engaged in practice in the city where he died.

**Indiana** is about to begin a hard fight for a good medical law. On October 15 a number of physicians assembled in Indianapolis to take the preliminary steps in the matter. A legislative committee was appointed to draft a bill. Since the Ohio law came in force Indiana's necessity for such a law has greatly increased by reason of a great influx of undesirable practitioners from our own State.

**Hamlin J. Andrus**, secretary of the Arlington Chemical Company was killed October 21 by the explosion of a dynamite bomb in his room at the offices of the Company in Yonkers, N. Y. The affair is involved in deep mystery. Mr. Andrus was a man respected by the whole community and was of domestic habit, so that it is difficult to frame a theory to account for the tragedy. Mr. Andrus was past middle life, a bank director, a church member and a public spirited citizen.

**Dr. I. M. Hatfield** of Warren, some months ago was convicted of criminal abortion and sent to the Penitentiary and at the same time the State Board of Registration and Examination revoked his certificate. Recently he has been paroled from the Penitentiary but the State Board was compelled to refuse to reissue him a certificate because he might at any time be ordered back into the Penitentiary. His only recourse, therefore, is a pardon and he has appealed to the Pardon Board.

**The Independent** Medical College of Chicago was incorporated October 15, 1896, by M. L. Reed, Minnie M. Wick, James Armstrong, Delia Hovey, Charles M. Hovey, Thomas Armstrong and C. K. Drumheller. Of these only the following are listed in Polk's Register as physicians: M. L. Reed, Rush College 1892, and James Armstrong, credited to no school at all. One of them, James Armstrong, is the head of the notorious Illinois Health University, against which the State Board has been fighting for a year, having secured an order from court revoking its charter, but the case is now in the supreme court.

**A case** illustrating in a graphic way one of the dangers lying in wait for the unwary physician has recently occurred in Pittsburg. A child 2½ years old was badly scalded on October 3. On October 9, the child being in very great pain the physician, Dr. George Gladden, prescribed 1-30 of a grain of morphin every two hours, if needed to control the pain. The child fell asleep after the first dose, slept twenty-four hours and died. At the inquest physicians testified that the dose was moderate and that the child died from burns. The physician was entirely exonerated. The druggist made no mistake in filling the prescription.

**Dr. Oscar Abert**, a German physician, was arrested in Chicago in the

act of selling a dental student a bogus diploma from the bogus Wisconsin College of Dentistry. He has done a good business, his diplomas selling at from \$25.00 to \$300 each. The police found \$2,000 in cash in his pockets. He expressed great annoyance at the American habit of interfering with his business.

**Dr. Paul Paquin** was criticised by some of his *confreres* at a late meeting of the St. Louis Medical Society for unethical methods of drawing attention to his antitubercle serum. In the *Republic* of October 15 he makes a vigorous reply closing by asserting that he and his associates "have followed the rules laid down in the code of medical ethics." The *JOURNAL* illustrated this fact in its last issue.

**The overcrowded** state of all the professions causes many and bitter complaints to go up against the established order of things. The man who has spent time and money to equip himself for professional life can see no justice in the enforced idleness and delayed remuneration which are almost universally his fate at the present day. A recent number of the *Medical and Surgical Reporter* discusses this subject well editorially. It was written *apropos* of complaints made by teachers that as a class they are too poorly paid. The well-established teacher, however, averages \$1,500 to \$2,000 a year while as the *Reporter* says: "Few will assert that the average physician has so great an income." Yet the teacher works not over seven hours a day for five days a week and for 40 weeks in a year; while the physician works twelve hours a day for six and one-half days a week and for 50 weeks in the year, besides the extra hardship of night work. However, "it is easier to see the thorns on our own roses than on our neighbor's."

"We are inclined to the opinion that a candid expression from the average member of any profession would emphasize the same two complaints, insufficient compensation and political machination." Among the 23,000,000 of our population engaged in "gainful occupations," 14,000,000 are "producers," 7,000,000 traders and carriers and servants, and 1,000,000 professional workers. The work of the latter deserves high remuneration but cannot command it so long as the disproportion in numbers to the real producers is so great. Our own profession is double the number needed and much the same may be said of the law and ministry.

In closing, the *Reporter* points out that, while the teacher is many times made the sport of the politician, yet "the professions, at whose entrance greater barriers are erected, like our own, or the ministry, or the military, are pervaded by a tendency to the development of an intraprofessional intrigue, which perhaps gives rise to more feeling and has as great disadvantages as the methods often brought to bear to secure advancement in the profession of pedagogy. Such things are no doubt regrettable but so long as the supply is greater than the demand and the spirit of competition for mere place is so keen there is no remedy."

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**P**EDIATRICS for October 15 contains an article by Dr. W. A. Walker, of New York, upon the modern treatment of diphtheria in private practice. He believes that the antitoxin treatment is a great advance in the therapeutics of this disease. He writes that he confidently expects to cure every case of diphtheria seen in private practice within 48 hours of the onset of the disease. In making the diagnosis, if it is at all doubtful, he



gives the child the antitoxin at once, and then sends a culture to the bacteriologist for a test. For a dose he gives 1,000 to 1,500 units of the serum. He at the same time orders a douche for the nostrils and throat of 1 to 5,000 bichlorid, or 1 to 4,000 potassium permanganate. At the end of 24 hours, if the diagnosis is clear, he gives a second injection of the antitoxin. At the end of 48 hours, if convalescence is not well begun, he gives a third injection. In the choice of the serum the author discards all foreign products. After repeated trials of domestic serum he has settled upon that made by Parke, Davis & Company. He especially approves of the bulbs in which the biologic department of this firm now puts up its serum, as in this way the serum is highly concentrated, hermetically sealed, and each bulb contains a dose. If the patient shows signs of absorption of poisons, he administers calomel in  $\frac{1}{4}$ -grain doses. He rarely uses alcohol, as it is seldom indicated along with the serum treatment. Fluid nourishment, especially milk, is all the patient is allowed.

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**D**R. Thomas Hubbard of Toledo in the *New York Medical Journal* of September 12, reports an interesting case of epithelioma of the soft palate which was removed by injections of *liquor potassae*. The growth was flat and tabular and occupied the junction of the soft palate with the right anterior pillar of the fauces. Small portions of *liquor potassae* were injected into the tissue of the tumor, and at the second sitting five separate injections of less than a drop each being made. Iced drinks kept down inflammatory reaction, and at the end of three days the growth sloughed away. The hole, of cherry size, healed readily after further slight destruction of remaining granular tissue. The patient improved promptly under the consequent return of power of deglutition. Examination of a portion of the tissue by Dr. Jonathan Wright of Brooklyn showed conclusively that the tumor was an epithelioma. The patient died two years later from other causes, and at the necropsy no return of the cancer was found.

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**I**N the *New York Medical Journal* for October 10, Dr. Harry C. Hayes, assistant physician to the Toledo State Hospital for the Insane, reports an interesting case of foreign body in the male urethra. The patient, a German farmer, aged 65 years, suffering from chronic melancholia which had lasted several years. His former physician reported that he was suffering from hypertrophied prostate, though his symptoms, slow, painful and intermittent urination, pointed more to vesical calculus. A sound met with obstruction just behind the meatus, which proved to be one inch of rubber tubing covered exteriorly with a heavy deposit of urinary salts, the lumen being freely open. Repeating the passage of a sound a second obstruction was met with at the penoscrotal junction. By palpation a foreign body about three inches in length, and made up of two parts, was found. This could only be safely removed by cutting through the posterior wall of the urethra, and it proved to be a hairpin. The sound now passed into the bladder and struck what seemed to be a true calculus. After a few days' preparation, median lithotomy was done, resulting in the removal of a phosphatic calculus 409 grains in weight and containing in its core a piece of coiled, fine iron wire. The ureters were not investigated.

**D**R. A. R. Baker of this city has a brief and systematic article upon Dermoid Tumors of the Cornea in the *Journal of the American Medical Association* for October 17.

The doctor gives a brief review of the literature of the subject and the theories of the origin of these tumors and their treatment, and reports two cases of more than usual interest. In one, the tumor was so large as to entirely conceal the eye-ball. It was attached to a little more than half of the cornea at its lower outer portion and extended close up to the sclero-corneal margin, but did not encroach much, if any, upon the conjunctiva. As a result of the operation the patient could read ordinary print. In the other case there were three small flat dermoid tumors of the left cornea, two at the outer sclero-corneal margin, and the other consisting of a fine line extending across the pupillary area almost at the center of the cornea. These were dissected off. Considerable opacity of the cornea resulted.

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**D**R. Carlos C. Booth of Youngstown in the *Medical Record* for September 26, reported an interesting case of collapse from excessive vomiting successfully treated by intravenous infusion of saline solution.

A millman aged 26 became suddenly ill on July 28 and began vomiting large quantities of rice-water like fluid, which continued at intervals until the evening of July 30, when he was in a state of collapse in spite of the use of every known remedy, especially morphin frequently and nitroglycerin and of sterile normal saline solution were infused into the right median basilic vein at 5 p. m., and the patient at once rallied continuing to gain steadily until August 7, when he was nearly well. In spite of treatment directed to that end there was no secretion of urine from July 28 to 31, and no movement of the bowels till August 1. The prompt improvement after the saline injection is very striking and points to the usefulness of this treatment in collapse from almost any cause, but especially, excluding hemorrhage of course, in cases of large loss of fluid from vomiting or diarrhea.

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**T**REATMENT of Uterine Disorders by the general practitioner. Dr. D. B. Maddox of Marion writes to the *Medical Summary* that medical treatment alone is efficacious in very many more instances than the surgical gynecologist admits. He reports two cases treated medically with success. The first one was of endometritis with tender ovaries, leucorrhea, scanty and irregular menstruation and dull pain in the back and abdomen. Hot boric acid solution, injections were ordered and also a drachm of dioviurnia with 15 drops each of the fluid extracts of cimicifuga and hydrastis, four times a day. Two months of this treatment sufficed for cure. The second case was one of dysmenorrhea and was successfully treated by a prescription containing 15 grains of sodium bromid, one drachm of dioviurnia and 15 drops of fluid extract of ergot to the dose, and, after the eighth week, elixir of iron, quinin and strychnin was also given. Outdoor exercise was insisted upon. In three months the patient had gained 16 pounds in weight. The doctor says he dislikes proprietary medicines, but that dioviurnia has proved of very great value to him.

### Unresolved Amygdalitis

In a paper with this title, read before the Northern Ohio Medical Society, July 8, 1896, published in the *New York Medical Journal* September 26, 1896, Dr. Howard S. Straight, of Cleveland, relates in detail the history of two cases of tonsillar inflammation, presenting the ordinary symptoms and local signs of acute amygdalitis. The ordinary local and constitutional treatment for this condition having failed to bring about the desired improvement, Dr. S. was led to examine the chest. In both cases he discovered evidences of "apex catarrh," the possibility of which, as a cause for the non-resolution of the tonsillar inflammation, he had overlooked at previous visits. In speaking of the second case he says:

"Upon close questioning, when she returned three weeks after being discharged as cured (?) from the acute amygdalitis, she told me that before the onset of the acute trouble she had felt very much tired out and that she had lost a few pounds of flesh within the last three months. If these two facts had been ascertained when she first presented herself complaining of her tonsil, my suspicions as to her chest would have at once entered my mind. Had I at this first visit prescribed Benzosol or creosote or guaiacol for her, and overlooked entirely any treatment for the tonsil, I would have saved the patient three weeks of suffering and myself a deserved humiliation. If I had the reputation of giving little thought to the importance of apex catarrh in diseases of the ear and upper air passages, if I had not insisted in season and out of season upon the importance of this constitutional condition in Cleveland at least, any such error on my part could be more easily explained. As to the pathology in a case of this kind I have little to say, for it seems to me that the pathologic process is no different from what it is in acute follicular amygdalitis in a healthy patient, but that for some reason the products of inflammation fail to be absorbed. I am equally at a loss to explain the wonderful improvement that occurs as soon as the patient is given some form of creosote. I do not wish it to be understood that every case of acute follicular amygdalitis in a patient suffering from apex catarrh pursues such a course as the cases reported. A certain proportion do pursue the anomalous course referred to, and they are difficult to understand if studied from the local standpoint only. The treatment early in the course of the disease need be no different than in the ordinary case, and yet the giving of Benzosol in small doses could do no harm if there is any suspicion of a localized bronchitis. Neither could any harm result from the administration of Benzosol if, after treatment with the ordinary remedies for a few days, the tonsillar inflammation fails to pass away. By so doing the patient is given the benefit of the doubt in any event. If, after acute follicular amygdalitis in which Benzosol is given on the suspicion that it was necessary, the patient's temperature and pulse are carefully observed, and an examination of the chest is made and nothing found, the remedy can be discontinued. In such a case, it is as good as any remedy with which I am acquainted. On the other hand, if a localized bronchitis is found, the best possible remedy, in my opinion, has been administered. The purpose of my paper has been accomplished if the necessity for a careful examination of the chest in cases of unresolved amygdalitis has been impressed upon you, and, indeed, in any diseases of the ear or upper air-passages.













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